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Ontario

ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.

Hearing held
8th floor
180 Dundas Street West
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange

P.S.A. Lamek, Q.C.

E.A. Cronk

Thomas Millar

Commissioner

Counsel

Associate Counsel

Administrator

Transcript of evidence
for

November 24, 1983

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FAY (cont'd)

X: Stratton

Roland

Chow

Kately

Kwan

Olak

Shanhan

Labow

Re: Ex. EAC




ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN
AND RELATED MATTERS.

Hearing held on the 8th Floor,
180 Dundas Street West, Toronto,
Ontario, on Thursday, the 24th
day of November, 1983.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
THOMAS MILLAR - Administrator
MURRAY R. ELLIOT - Registrar

APPEARANCES:

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	and Coroner's Office)
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M. THOMSON)	Sick Children
R. BATTY)	
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	Toronto Police
K. CHOWN	Counsel for numerous Doctors
	at The Hospital for Sick
	Children
F. KITELY	Counsel for the Registered
	Nurses' Association of Ontario
	and 35 Registered Nurses at
	The Hospital for Sick Children



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APPEARANCES: (Continued)

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G.R. STRATHY) E. FORSTER)	Counsel for Phyllis Trayner - Nurse
J.A. OLAH	Counsel for Janet Brownless - R.N.A.
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S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes, and Mr. & Mrs. Murphy (parents of deceased children)
F.J. SHANAHAN	Counsel for Mr. & Mrs. Dominic Lombardo (parents of deceased child Stephanie Lombardo); and Heather Dawson (mother of deceased child Amber Dawson)
P. KRAWEC	Counsel for Mr. & Mrs. Hines (parents of deceased child Jordan Hines)



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---Upon commencing at 9:30 a.m.

DR. JOHN E. FAY, Resumed

THE COMMISSIONER: Yes, Miss Cronk.

MS. CRONK: Good morning, sir.

Good morning, Doctor.

THE WITNESS: Good morning.

MS. CRONK: Mr. Commissioner, I have spoken briefly to my friend Mr. Strathy and with his indulgence. You will recall that yesterday you asked Dr. Fay whether or not he was in a position if possible to place certain of the children whose deaths had been ascribed to natural causes in yet another category, if you will, and you described it as a category where there wasn't any sensible rational conclusion that anybody could reach that that child had died of digoxin intoxication.

THE COMMISSIONER: Yes.

MS. CRONK: Dr. Fay has told me this morning that he has considered that matter and is prepared now to give you his views.

THE COMMISSIONER: Yes, all right.

THE WITNESS: Yes, Mr. Commissioner. I went over the notes on the children in Category 5 of conclusions reached by myself. It seems to me



1
2 that there are eight which I would now put into, as
3 you express it, as I understood you to express it,
4 no sensible conclusion that the child had died of
5 digitalis intoxication. The outstanding case would
6 be Bruce Floryn, who is a 19 year old, who was
7 extremely ill, but the others that I have also
8 included after review are Alan Perreault, Paul
9 Murphy, Laurette Heyworth, Frank Fazio, David Leith,
10 Barbara Gionas and Charlon Gardner.

11 THE COMMISSIONER: Yes, thank you,
12 Doctor.

13 MS. CRONK: Thank you, Dr. Fay.
14 Mr. Commissioner, you will recall yesterday as well
15 that Mr. Strathy, amongst others, asked whether or
16 not it would be possible for the original index cards
17 completed by Dr. Fay to be produced. They have just
18 been provided to us this morning and they are
19 available for other counsel to look at should they
20 wish to do so.

21 THE COMMISSIONER: Yes, all right,
22 thank you.

23 MS. CRONK: Thank you, sir. I'm
24 sorry, sir, there was one other housekeeping matter.

25 THE COMMISSIONER: All right.

MS. CRONK: Yesterday you will



1
2 recall as well there was a request made that
3 Dr. Hastreiter's report be marked as an exhibit at
4 this stage, subject to his later identification
5 when he attends.

6 THE COMMISSIONER: Yes.

7 MS. CRONK: And we now have a copy
8 available to be marked.

9 THE COMMISSIONER: Yes, all right.
10 What number are we at?

11 THE REGISTRAR: 264.

12 THE COMMISSIONER: 264.

13 ---EXHIBIT NO. 264: Dr. Hastreiter's Report.

14 MS. CRONK: I should say, sir, that
15 the copy of his report that has now been marked has
16 been distributed for some time now to all counsel.

17 THE COMMISSIONER: Yes.

18 MS. CRONK: Thank you, sir.

19 THE COMMISSIONER: I have nothing
20 against Dr. Hastreiter but it seems to be a particu-
larly large report.

21 Yes, all right, Mr. Strathy.

22 MR. STRATHY: The only outstanding
23 housekeeping matter, Mr. Commissioner, relates to
24 my request for the minutes of the meeting which the
25



1
2 witness referred to yesterday. I'm advised by
3 Mr. Young that he has reviewed the position of his
4 client overnight and, as I understand it at least,
5 takes the position that there is nothing relevant
6 in those minutes and is declining to produce them.
7 I would like at least the opportunity to satisfy
8 myself as to those minutes. I'm not questioning in
9 any way Mr. Young's view but what might be relevant
10 to him...

11 THE COMMISSIONER: Yes. Have you
12 any objection to Mr. Strathy seeing them; I don't
13 say that you may not have one, if you have one, but
14 do you have any objection to him seeing them?

15 MR. YOUNG: I do have an objection,
16 Mr. Commissioner.

17 THE COMMISSIONER: You do have an
18 objection, all right.

19 MR. YOUNG: Mr. Commissioner, I
20 guess I should explain very briefly, if I might,
21 as to why we are not consenting to Mr. Strathy
22 seeing them, for these minutes to be disclosed.

23 THE COMMISSIONER: Yes.

24 MR. YOUNG: We have made submissions
25 and in fact you have made a descision on interpreting
the Terms of Reference.



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THE COMMISSIONER: Yes.

MR. YOUNG: There is no doubt that the situation now is that we are not to be looking into the police investigation that occurred after May 21st.

THE COMMISSIONER: Yes.

MR. YOUNG: Dr. Fay was good enough to assist the Crown and the police after that date and did not have any involvement prior to that date.

As Mr. Lamek mentioned the other day, the only minutes that are relevant to the cause of death are the minutes that have been produced with one small exception, I think there may be one or two passages in another set of minutes that Mr. Lamek intends to produce or introduce through Dr. Hastreiter and at that time we would like to review those passages and we may indeed have no objection. But it is not because we are trying to suppress information that would assist you, Mr. Commissioner, in determining the cause of death, it is simply because the bulk of this information deals with areas that we would submit are Crown privilege or are directly related to the subsequent police investigation and for us to produce that at this time we would not see the relevance and would feel that we have to present



1
2 further evidence to explain the context of these
3 meetings and if we are not going to conduct an
4 entire enquiry into this second police investigation
5 we don't see that these minutes should be disclosed.

6 THE COMMISSIONER: Well, I think
7 what I might do, and I don't know whether this is
8 so, but I will just have to look at them and together
9 with Commission Counsel summarize not what they say
10 but what the subject matter is.

11 MR. YOUNG: Well, that would be fine.

12 THE COMMISSIONER: And then we
13 could have an argument on the problem.

14 MR. YOUNG: That would be fine,
15 Mr. Commissioner.

16 THE COMMISSIONER: Because we haven't
17 solved the question of the police report yet because
18 you haven't yet presented us with what your proposal
19 is or what your reaction to our proposal is.

20 MR. YOUNG: And then we will be
21 giving you an answer shortly, Mr. Commissioner.

22 THE COMMISSIONER: So, I think we
23 will have to do all that at the same time. I don't
24 see any other solution to it, Mr. Strathy.

25 MR. YOUNG: Mr. Commissioner, I'm
sorry, if I might just make one final comment.



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THE COMMISSIONER: Yes.

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MR. YOUNG: The particular minutes of the meetings that we are talking about are in the police report, as you probably know.

6

THE COMMISSIONER: Yes, yes.

7

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MR. YOUNG: As Mr. Lamek revealed yesterday.

9

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11

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THE COMMISSIONER: Yes, and when I said I didn't know what was in them I probably didn't tell the truth because I have read the police report but I just didn't - they couldn't be that vital because I don't remember.

13

14

MR. YOUNG: Those are all my comments, Mr. Commissioner.

15

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THE COMMISSIONER: All right. Well, Mr. Strathy, I don't see what else we can do.

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MR. STRATHY: That is satisfactory, Mr. Commissioner.

THE COMMISSIONER: When we find out how far he's prepared to go, then I will worry about that; the rest of it I will have to summarize for you and without giving you the details and then if you still think you are entitled to them we will have to have an argument.

24

25

MR. STRATHY: That's quite



1
2 satisfactory, Mr. Commissioner.

3 THE COMMISSIONER: All right.

4 CROSS-EXAMINATION BY MR. STRATHY: (Continued)

5 Q. Doctor, when we ended the day
6 yesterday I was asking you some questions in relation
7 to Baby Jordan Hines and the reference is to your
8 report at page 83 and the minutes of the meeting of
9 September 13th at page 221. My question was in the
10 context of your notes and the yellow cards that you
11 prepared and the police have now produced the
12 original documents.

13 A. Yes.

14 Q. Does it help you, Doctor, by
15 looking at these cards, to determine when it was
16 that you wrote the A's, B's and C's on the cards?

17 A. I think I had categorized these
18 prior to the meeting which fits with - I have given
19 it a lot of thought and I am practically certain
20 that I did.

21 Q. All right. And in that regard
22 if you could look at the card for Hines, the bottom
23 left hand corner you have a B.

24 A. Yes.

25 Q. And as you note on your hand-
written notes you had a possible.



1

2

A. Which would coincide.

3

4

Q. That's what I would have thought,
yes. My question is, do you know when it was that
you changed the B to an A on that Hines?

5

6

A. I think it must have been at
the meeting.

7

8

Q. At the meeting?

9

A. Yes.

10

Q. Is that your best recollection
today then?

11

12

A. That's my best recollection,
yes.

13

14

Q. So, some time after you heard
the views of the other parties involved?

15

A. Yes.

16

17

Q. So, we can take it then that
your original view of the case before hearing the
other parties was that it was a possible or a B, is
that fair?

18

19

A. Yes.

20

21

Q. And I gather from your evidence
that what caused you to move it up to an A was the
toxicological evidence that you heard at the meeting?

22

23

A. Yes, I think so, the general
discussion I heard at the meeting, yes.

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Q. Thank you.

Mr. Commissioner, unless you or some other party want the originals filed I don't purpose to file them, at least at this stage.

THE COMMISSIONER: No. Well, all right, we will just leave them then and see what happens.

MR. STRATHY: Q. Doctor, can I ask you to turn to Baby Stephanie Lombardo, that is to be found at page 60 of your report and at page 225 of the minutes.

Just looking at your notes at page 60, would you agree with me that this child Lombardo was a very sick baby with severe congestive heart failure?

A. Yes.

Q. Doctor, you have made a note that, I believe it was on the 17th of December, the child had an aortic pulmonary shunt.

A. Excuse me, excuse me, which page are we looking at?

Q. Page 60 of your notes.

A. Oh, sorry, yes, all right.

Q. You made a note that this infant had T of F, tetralogy of Fallot.



1

2

A. Yes, yes.

3

Q. And underneath that 17/12 the

4

child had an aortic pulmonary shunt.

5

A. Yes, yes.

6

Q. Now, Doctor, in this case we

7

have heard that there was no autopsy performed after

8

the child's death but it has been posited as an

9

explanation for the child's death that there was a

10

shunt occlusion?

A. Yes.

11

Q. Leading to the ultimate death

12

of the child. Are you able to say whether you are

13

prepared to accept shunt occlusion as a likely

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cause of death from, at least, a clinical standpoint?

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B:
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A. Oh, if the shunt occluded in this baby, yes, yes, that would have resulted in death.

Q. That would account for the child dying when she did and in the manner she did?

A. Yes, it could have, yes.

Q. And I note at the top of the page you rank the child as "possible", may I take it that was your view after reviewing the child's chart and the information contained in the chart?

A. Correct.

Q. And just looking over the page you have, on page 61, you note: "Child not supposed to be receiving digoxin"?

A. Yes.

Q. You also have: "toxicology information"; and just looking at your original notes that information seems to be in the same pen. Would it be fair to conclude that you had that information at the same time as you reviewed the chart?

A. Oh I think so, yes. Well, you know, I am not sure; yes I think so, yes, as best as I can remember.

Q. So that your assessment of "possible" then was made with the knowledge of the toxicology data such as it was at that time?



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A. Yes, I think that is true, yes.

3

Q. And if you look at the minutes,

4

Doctor, page 225, the second paragraph on page 225

5

apparently states your views, and you state:

6

"Dr. Fay reviewed charts and agreed

7

that death was somewhat unexpected.

8

He stated that digoxon overdose is a

9

possibility, but the question is how

10

strong?"

11

And stopping there, Doctor, obviously you are

12

recounting your views as a "possible" which are set
out in your notes?

13

A. Yes.

14

Q. "He raised the points that the

15

baby was seven days post-operative and appeared to

16

be doing well. One would have to be suspicious

17

but he stated it would be hard to put it to 'probable
murder'."

18

Now that also would seem to accord with

19

your view that it was a "possible", is that fair?

20

A. Yes, it is.

21

Q. And you say:

22

"Dr. Fay stated that things that raise

23

concern were already pointed out. The

24

baby was only ten days old, had serious

25



1

2

"heart disease, and these babies do die
in these circumstances."

3

4

Again you have already told us that sudden death is
something that happens in your experience?

5

A. Yes.

6

7

Q. "However, Dr. Fay stated he
would be suspicious."

8

A. Yes.

9

10

Q. Now then Mr. Cimbura proceeds
to give his views on the tissues, and just underneath
the portion I quoted from your evidence, or your
submissions at the meeting it says:

11

12

"Mr. Cimbura stated that they only had
exhumed tissues, ..."

13

14

Would that suggest to you that Mr. Cimbura felt
that exhumed tissues were perhaps somewhat unreliable,
or inconclusive?

15

16

17

A. I certainly got the impression

18

19

from Mr. Cimbura that in several, or perhaps many
of these cases where he was discussing levels in
tissues from babies whose bodies had been exhumed,
that he was not in a position or prepared to state
categorically whether this was purely, you know,
abnormal toxic; and I gather that as a toxicologist
there was little in the literature, or little in

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25



1
2 his past experience on which he could really base
3 an unequivocal opinion as to the significance of
4 this or that or the other level.

5 Q. And that would seem to accord
6 Doctor, with the next paragraph underneath Mr.
7 Cimbura's findings, where it says:

8 "To summarize, Mr. Cimbura said the
9 mere finding of digoxin is significant
10 because this child was not on digoxin
11 therapy. However, purely from a
12 toxicology point of view, Mr. Cimbura
13 said these findings were inconclusive."
14 Which seems to accord with your recollection of what
15 he said?

16 A. Yes.

17 Q. What confuses me, Doctor, is
18 that we go on, and after your initial view being
19 suspicious but hard to put it "probable murder"
20 after Mr. Cimbura saying that the findings are
21 conclusive, the vote is then taken and your
22 opinion jumps from "possible" with the reservations
23 you have expressed to "probable murder".

24 May I ask you, is that vote on your
25 part of "probable murder" influenced by your concern
that had been expressed to you by the police in coming



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to some form of consensus so that the parents could be advised?

A. You know I am not in the habit of using "murder" freely and it doesn't come easily to me. If I were in a different occupation I am sure that it would be used more freely, it doesn't come easily, it is not something I use. I think it would be fairer to state that I moved from the "possible" to the "probable" and that I did that on the basis of the toxicology because I am told here we see digoxin and we don't know what these levels mean in terms of toxic levels during life but the baby wasn't supposed to be on digoxin, I think that is why.

Q. I would like to know, Doctor, and to assist the Commission, we would all like to know when you moved from "possible" to "probable" are you saying it is probable that digoxin was administered to the child; or are you saying it is probable that digoxin had some involvement in the death of the child?

A. I think in the context of the meeting which I was attending it means the latter.

Q. Probable that it had some involvement in the death?



1

2

A. In the death of the child, yes.

3

4

Q. Surely the only way to know that would be to have pharmacological evidence that would interpret those findings of Mr. Cimbura?

5

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A. That is correct I would say.

I think again that - I think again that we are moving between areas here of purely medical and something other than that. I think that is the only logical explanation that I can give you as a physician.

11

12

13

14

15

Q. May we take your answer that you have just given us to apply to all these findings when you have said "probable murder" you are not qualified to say whether murder or not, you are really saying probable digoxin involvement in the death?

16

17

18

19

20

21

A. If I was using "murder", I didn't use "murder", I was never asked to look at these charts to decide about that point, that is not my job. I was asked to give an opinion as to whether digoxin toxicity might have been responsible for the child's death in any given instance, and that is what I tried to do.

22

23

24

25

Q. I would like to know, may we interpret your votes in that context, that is that



1
2 it is probable that digoxin toxicity might have
3 contributed to the death of the child.

4 A. I think that is the only
5 interpretation.

6 THE COMMISSIONER: I think there are
7 too many ---

8 MR. STRATHY: Might's?

9 THE COMMISSIONER: I think there are
10 too many might's in that.

11 MR. STRATHY: I thought the witness used
12 might's.

13 THE COMMISSIONER: If it is probable that
14 it would is the same as it might I think, isn't it,
15 probably it might and reduced a little below. I
16 think we are going too far into that. You want to
17 use the word "probable".

18 THE WITNESS: Yes.

19 THE COMMISSIONER: Probable that digoxin
20 had something to do with the death of this child.

21 THE WITNESS: Yes, Mr. Commissioner,
22 all of this really is degrees of probability.

23 THE COMMISSIONER: Yes. Well, that is
24 going to make it more difficult for us.

25 THE WITNESS: Is it?

THE COMMISSIONER: We have to have



1
2 something, and I suppose you can say that this is
3 something between possible and probable if you
4 want to, you can say very possible as you did on
5 one occasion.

6 THE WITNESS: Yes.

7 THE COMMISSIONER: With respect to a
8 good possibility with respect to Jordan Hines.

9 THE WITNESS: Yes.

10 THE COMMISSIONER: But you rated the
11 others "probable" and "possible"?

12 THE WITNESS: Yes.

13 THE COMMISSIONER: And a good possibility,
14 and I take it at that time at any rate, I am not
15 going to say, I will leave it to Mr. Strathy to
16 find out what you think now, but at that time in
17 any event so far as Lombardo was concerned he was
18 a "probable", "probably" I think, was he, was she?

19 MR. STRATHY: She.

20 THE COMMISSIONER: She, yes, that is
21 right at the very top, yes, probably digoxin
22 contributed to the death of the child.

23 THE WITNESS: Yes and I have to stick
24 by that because I am told that this baby wasn't
25 on digoxin, and here Mr. Cimbura although he doesn't
know the significance in terms of the ante



1
2 mortem digoxin levels he is telling me he has
3 found digoxin, whereas the baby was not supposed to
4 be on digoxin at all.

5 THE COMMISSIONER: May I ask you, Doctor,
6 it seems to me that that is the only evidence in
7 front of you which indicates to me that digoxin
8 played any role in the death of the child, namely
9 that the child was not on digoxin but apparently
10 received it?

11 THE WITNESS: I would say that is so,
12 yes.

13 MR. STRATHY: Q. Is it also fair to
14 say, in view of what Mr. Cimbura said, that you are
15 really totally unable to say the extent to which
16 digoxin played a role in the death of the child?

17 A. That is true.

18 Q. And indeed it may be, Doctor,
19 that the child may have received some digoxin prior
20 to death which had nothing to do with the child's
21 death?

22 A . That is also true.
23 -----
24
25



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C: 2
EMT: 3
yk 4

Q. Could I ask you to turn to Baby Belanger (your notes on that child are on page 63 and following) and also the minutes at page 227, at the bottom of the page.

5

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A. The notes on the minutes are on page 227?

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Q. Yes. Now if you look at page 65, Doctor, at the top of the page may we take it that that note "possible and likely" in the upper right-hand corner was made at the time of your chart review?

12

13

A. Yes, I think it has to be. I think that that is the time it was made.

14

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Q. And if you can turn over the page to page 66 you have a note that the child was not supposed to be receiving digoxin therapy, and in reference to an exhumed muscle of 43 - presumably 43 nanograms per gram ---

18

19

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A. Microgram, yes.

Q. Within normal range.

A. Yes.

Q. May we also take it that you had that information before you when you ranked this child "possible and likely"?

A. I don't know on which day I



1

2

wrote this note. I made several visits to the

3

Hospital for Sick Children.

4

Q. Well, let me put it this way --

5

A. Yes.

6

Q. Was that note concerning

7

"possible and likely" and the reference to the

8

digoxin therapy, that the child was not on digoxin,

9

was that made as a result of your chart review

10

rather than at the meeting?

A. I think ---

11

Q. To assist you, Doctor, it

12

appears to be in the same ink on your original

13

notes.

A. Yes, it does. Yes. Yes,

14

I would say probably I did write it at the same time.

15

Q. So it would be reasonable for

16

us to conclude that when you put that "possible and

17

likely" on the note you had before you this information?

18

A. As far as I can remember,

19

yes.

20

Q. And that information given to

21

you at that stage would suggest that the child had

22

received some digoxin prior to death?

A. Yes.

23

Q. Even though not supposed ---

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A. Not supposed to be, yes.

3

Q. Not supposed to be receiving it?

4

A. Yes.

5

Q. Is that something incidentally

6

that you could envisage as happening at a hospital

7

complex, a hospital the size of the Sick Children,

8

through inadvertence perhaps a child might receive

a dose of digoxin?

9

A. Oh, yes, yes.

10

Q. Digoxin is a very common drug

11

in the Heart Ward?

12

A. Very.

13

Q. So it is not certainly outside

14

the realm, in your view, of possibilities that that

could happen in the Hospital?

15

A. No, not at all.

16

Q. And looking at the minutes,

17

Doctor, Exhibit 261, page 227?

18

A. Yes.

19

Q. The second paragraph under

20

Belanger?

21

A. Yes.

22

Q. You say:

23

"Dr. Fay reviewed the charts -" -

you don't say it; the minutes say it:

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"Dr. Fay reviewed the chart and stated that an important point was that, although the heart problem was severe, the infant was well enough to leave I.C.U. He said that one would have to be suspicious, but how suspicious is the question."

And that appears to accord with your view in your notes?

A. I think so.

Q. Is that to your recollection an accurate representation of what you stated at the meeting?

A. You know I can't remember each case but I am sure this is - I think this is accurate, yes.

Q. Then we have Mr. Cimbura really saying things similar to what he said in the case of Hines; that the toxicology information was really inconclusive.

A. Yes.

Q. Once again, Doctor, over the page, page 228, where a vote is taken you move the child from "possible and likely" to "probable murder", and can we take it that your vote in the



1

2 case of this child means the same thing that you
3 told us in the case of Hines really?

4

A. Yes, I would say so.

5

6 Q. And that the thing, the only
7 evidence that you can really point to in saying
8 probable that digoxin contributed to the child's
9 death is the fact that the child had digoxin in
10 the system apparently when she was not supposed
11 to receive it?

10

A. Correct.

11

12 Q. And once again you really
13 can't say to what extent if at all that digoxin
14 contributed to the child's death?

13

A. No, I can't.

14

15 Q. Would you move to Kristin
16 Inwood, Doctor? At page 94 of your notes. I will
17 give you the reference. Page 222 of the minutes
18 of the meeting.

18

19 Looking at page 94 of your notes,
20 the very bottom of the page?

19

A. Yes.

20

21 Q. You referred previously to
22 your evidence, "Child given 'Lasix' just prior to
23 developing critical symptoms".

23

24 Do I understand your evidence to be

24

25



1
2 the reason you put that Lasix in quotes was there
3 was at least some question in your mind as to
4 whether or not it was in fact Lasix?

5 A. Yes, I think that is the
6 interpretation that I would make of this note of
7 mine at this time.

8 Q. It was described in the chart
9 as being Lasix, but for one reason or another you
10 had a question in your mind?

11 A. Yes.

12 Q. I wonder if I could see Exhibit
13 113, please?

14 Doctor, this is a chart of Baby
15 Inwood, at page 63.

16 I think the only other chart I will
17 be referring to, Mr. Registrar, for your assistance,
18 is the Miller chart.

19 Page 63, Mr. Commissioner.

20 You will see, Doctor, there is a
21 reference about four lines down?

22 A. Yes.

23 Q. To Lasix having been given at
24 2310.

25 A. Yes.

Q. Then at 0200 monitor strip



1

2

showed abnormalities TL - that is team leader note?

3

A. Yes.

4

Q. Resident called. Lasix given.

5

Lasix 3 milligrams given IV by resident.

6

And then we have tachycardia, 200
beats, baby irritable, very irritable apparently.
0230 25 cardiac arrest call.

8

Was it that latter reference to
Lasix that caused you to put your note at page 94?

10

A. I think it must have been,

11

yes.

12

Q. And was the reason for your
concern with respect to the Lasix or your question
with respect to Lasix the fact that the child had
seemed to develop critical symptoms shortly after
receiving that Lasix dose?

16

A. I think that is the only
reasonable explanation I can give at this time.

18

Q. That there was some form of
temporal relationship between ---

19

20

A. Between the injection - mind
you, furosemide is a powerful diuretic and it can
cause shifts of the electrolytes very rapidly,

22

especially in a young baby. But the fact I put it

23

in parenthesis, inverted commas, must be as you say

24

that I was wondering if it really was Lasix that the

25

child received.



D/BB/ak

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Q. And if it was not Lasix that the child received, what was it in your mind that the child might have received?

A. Digitalis digoxin.

Q. And do you say that is something that is within the realm of possibility, certainly not a happy event, but something that's within the realm of possibility in your experience that digitalis could have been confused with lasix?

A. Oh, I think it could have been confused in a situation where at this hour a resident is called by a concerned staff person and, really, it is very difficult to know, you know, whether the child needs more diuresis or what's to be done. Yes, I think so, I have seen the setting in a clinical urgent situation many, many times of course in my career, so, of course, it is a situation where that might occur.

Q. And when you say at this hour, do you mean in the early hours of the morning?

A. Yes.

Q. Thank you. Doctor, I am not going to belabour the point on the Inwood child but I do want to ask you this. You were examined at some length by Mr. Brown yesterday about the child



1
2 and you mentioned that while your initial opinion
3 was possible, not very likely, as we see at page 93
4 of your notes, the top of the page, you said it was
5 not very likely to begin with, but you said you
6 ultimately changed your mind as a result of the
7 toxicology information.

8 A. Yes.

9 Q. But if we look at the bottom
10 of page 223 where you made your first vote, bottom
11 of page 223 beside Dr. Fay it says "Low suspicion",
and the comment is:

12 "Would rule out the possibility of
13 overdose; it would be difficult to
14 be absolutely convincing from the
15 toxicology analysis."

16 So, that note at least suggests that
17 you considered the toxicology and your view was
18 nevertheless low suspicion and indeed the toxicology
gave you serious questions in your mind.

19 A. Yes.

20 Q. And then we go over the page.

21 THE COMMISSIONER: I'm sorry, before
22 you leave that. Is that a correct - is it "Would
23 rule out..." or "Would not rule out..."?

24 THE WITNESS: I think it must mean
25



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"Would not rule out..."

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THE COMMISSIONER: Yes, it doesn't
make sense.

5

6

THE WITNESS: It doesn't make sense
otherwise.

7

8

THE COMMISSIONER: You say "Would
rule out the possibility of overdose;" because then
it would be natural death.

9

10

11

THE WITNESS: Yes, thank you. It
must mean "not rule out", otherwise, I can't have
a low suspicion.

12

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MR. STRATHY: Q. Well, it appears
at least on the first vote that you are expressing
fairly serious reservations, Doctor, and it is in
the low suspicion category and then you all received
the admonition of Sergeant Press to present a
united front and then at the bottom of the first
paragraph on page 224 it says:

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"Dr. Hastreiter said that if this
information is acceptable, he would
say 'Probable', but from the way
Mr. Cimbura feels about it, he did
not think this toxicology evidence
would hold. From a clinical stand-
point, Dr. Hastreiter said this death



1

2

"would be in the 'Suspicious' category
at the most."

3

4

And then three paragraphs down

5

Mr. Cimbura gives his views again and it says:

6

"Mr. Cimbura stated from a scientific
point of view, it is an unusual
finding; 200 was about the highest
for serum. From that point of view,
a scientist is very uneasy.

7

8

9

10

Dr. Hastreiter stated he felt the
same way; did not understand how such
a high level could remain before
death; digoxin would have to have
been given 1 or 2 minutes before
death."

11

12

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16

Again, the toxicology information
that is reviewed after the first vote seems to
cast further questions on the whole issue.

17

18

A. Yes.

19

20

21

22

Q. It just seems to me reading it
that the toxicology does not really explain why you
have jumped from low suspicion to probable, whatever
you want to call it.

23

24

25

A. There is another paragraph
as you see after the one referring to Mr. Cimbura



1
2 who makes that statement about the child being
3 given something intravenously March 13th, which was
4 the day of the child's death.

5 Q. The reference to the 6 milli-
6 litres?

7 A. Yes. I'm not sure now, you
8 know, exactly what the referred to or what was meant
9 by that.

10 Q. Well, that's carried through
11 in your note as well, or at least in the report of
12 what you said at the time of the vote - excuse me,
the minutes, Doctor, at the bottom of 224.

13 A. Yes.

14 Q. Opposite your name it indicates
15 that you felt 6 millilitres was a big dose for a
16 baby.

17 A. Yes. I can't remember the
18 details of that 6 millilitre dose or what we were
19 actually speaking of at that time, I don't know,
I can't remember.

20 Q. Would you agree with me though
21 that there is really nothing in the toxicology, at
22 least as recorded at that meeting, after the first
23 vote which would have caused you to change your mind?

24 A. No, there doesn't appear to be.
25



1
2 I think that one of the purposes of the meeting was
3 to identify the group of children where it was
4 felt, and this had been discussed previously, there
5 was, from the practical standpoint, no good reason
6 to suspect digitalis overdoses so that those parents
7 could be informed. That I think was understood
8 prior to this meeting.

9 So that there was a factor here that
10 may have been operating too to move it one or the
11 other, you know, either, as you see natural causes
12 was the term used, or the possibility remaining, and
13 that may have been a factor too. I understand after
14 this meeting, and I didn't learn this until I came
15 here for these hearings, that the children were
16 divided into two categories, which, you see, I haven't
17 still got them into two categories.

18 Q. Well, was that something in
19 your head at the time, that is, in the course of
20 this discussion you were trying to determine which
21 parents can we go to and say you needn't worry about
22 your child. Is that something you were thinking
23 about at the time?

24 A. You know, this is 14 months
25 and to sit here and say I remember distinctly I
don't know. I'm going over this now for really the



1
2 sixth time in the last two days, but I mean, the
3 first time in the last 14 months and I cannot
4 truthfully say what influence that had on the
5 thinking. Clearly there was some influences here
6 to make us change from possible to probable.

7 Q. Well, that's what I'm getting
8 at, Doctor, I am trying to determine what it was
9 that caused you to move from possible, not very
10 likely, to probable. You have said toxicology, but
11 I think you have agreed there is nothing ---

12 A. Well, you see Dr. Hastreiter's
13 comment too is:

14 "Digoxin level is very high unless
15 this sample is a total disaster.
16 Tissue samples support the high serum
17 level."

18 Now, Dr. Hastreiter is very knowledge-
19 able in this field.

20 Q. I'm sorry, where are you
21 referring to?

22 A. Aren't we talking of the ---

23 Q. Which page?

24 A. Well, page 224, wasn't that
25 where we were? Yes, 224 where we referred to the
6 millilitres where you've got the final vote.



1

2

Q. Yes, I see, after his vote.

3

A. He says:

4

"Digoxin level is very high unless

5

this sample is a total disaster.

6

Tissue samples support the high serum
level."

7

8

So, that also influenced me too. That
was his second comment.

9

10

Q. How were these votes taken, one
at a time?

11

A. Yes.

12

13

Q. So, Dr. Hastreiter made his
vote followed by your vote?

14

A. Yes, I think so.

15

16

Q. Are you saying then that your
vote would have been influenced by Dr. Hastreiter's
vote?

17

18

A. Not by his vote necessarily
but certainly by his comments. As I have said
repeatedly, this was a meeting to obtain a consensus.
This was the first time we were sitting down as a
group and discussing all this. We hadn't done this
before, I had never sat down with Dr. Hastreiter
before, I had never gone over this with him before.

19

20

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Q. So, I gather to some extent at



1
2 least your vote was influenced by the views he
3 expressed when he made his vote?

4 A. That was another factor, yes.

5 MS. CECCHETTO: In fairness to
6 Dr. Hastreiter's comments with respect to the tissues
7 they
8 are in the first paragraph on page 6 and second
9 paragraph when Jerry Wiley and he have the exchange
10 about the high level and the other areas.

11 MR. STRATHY: Yes.

12 MS. CECCHETTO: So, it doesn't
13 appear for the first time when he expresses his views
14 on the vote, it has appeared earlier on if you read
15 them, in the first and second paragraphs, in the
16 entirety.

17 MR. STRATHY: Q. Just so that we
18 are all clear on a point, Doctor. When you were
19 expressing your views as to probable and possible
20 and so on.

21 A. Yes.

22 Q. Was it in your mind that it
23 was better to err on the side of probable so as to
24 keep anything there was a suspicion within that
25 probable group?

A. That's an interesting point,
you know. I can't really say surely that that was



1
2 a factor in my deliberations. I was trying to give
3 an answer to a question which had been posed. I
4 was doing my best. I had what you see before you
5 in order to make that decision, a clinical chart,
6 no discussion with anybody who looked after the
7 children during life, some toxicology which was
8 difficult to weigh at times even for the toxicologist,
9 and one group discussion, the purpose of which was,
10 one of the purposes of which was to categorize certain
11 children as not being under any suspicion of having
12 died of digitalis overdosages so the parents could
be informed, and that is all I had to go on.

13 Q. No, I realize that and I don't
14 want to interrupt you except that I don't think you
15 are answering or responding to my question. My
16 question is simply whether you had that in your
17 mind as an influence, that it was better to put it
18 in the probable category if there was any doubt in
your mind?

19 A. I think that may well be true.
20 This had been going on for me for some time looking
21 at charts and this was a meeting at which some
22 decisions had to be made. What was going to happen
23 after that was unknown to me, or I suppose to anybody
24 else for that matter, you can't foretell the future,
25



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2

but, yes, I suppose that was a factor.

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6

Q. Thank you. Could I ask you now to look at the chart or the minutes of Baby Allana Miller. Your notes are found at page 99. I wonder if we could have the chart.

7

THE COMMISSIONER: It is there.

8

9

10

MR. STRATHY: Q. Doctor, just by way of general observation, you have made your notes with respect to the Miller child at the top of page 99.

11

A. Yes.

12

13

14

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Q. And I might indicate to you that in the evidence of Dr. Rowe and Dr. Bain it was mentioned that this child, Allana Miller, was classified by the doctors at the Hospital as a baby being at a high risk of dying as a result of her cardiac problems. Would you agree with that observation?

18

19

THE COMMISSIONER: Can you just pause just briefly?

20

21

THE WITNESS: Yes, I would say that's true.

22

23

MR. STRATHY: Q. Well, the Commissioner asked you to pause.

24

25

THE COMMISSIONER: If you can just



1

2

pause just briefly.

3

THE WITNESS: Yes.

4

THE COMMISSIONER: Yes, yes, all

5

right, I'm sorry, the question was?

6

MR. STRATHY: Well, I simply asked

7

the witness whether he would agree with that

8

observation that the child was at a high risk of
dying due to her cardiac condition.

9

THE WITNESS: Yes, the child had

10

common atrium and pulmonary hypertension.

11

MR. STRATHY: Q. Common atrium

12

and pulmonary hypertension?

13

A. Yes.

14

Q. And given those conditions,

15

Doctor, would she be at risk of dying in precisely
the way she did?

16

A. Well, I don't know what her

17

pulmonary artery pressure was but certainly children
with pulmonary hypertension can die suddenly.

18

19

Q. Thank you. You mentioned

20

in your evidence, although I don't see it recorded
in your notes, that this child received a dose of
Lasix shortly prior to her death. Would you look
at page 42 of her chart, please.

21

22

23

A. Yes.

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Q. About three-quarters of the
way down page 42 there is a note, middle of the
nurses' notes:

"Dr. Soulioti came to examine child
and administered Lasix 6 milligrams
IV push at 0240."



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THE COMMISSIONER: I haven't found it.

MR. STRATHY: Three-quarters of the
way down page 42.

THE COMMISSIONER: Oh yes, yes,
thank you I have it.

Q. "Dr. Soulioti came to examine
the child and administered Lasix
6 milligrams IV push at 0240. At
approximately 0245 babe began to
seizure ..."

It looks like:

"... i.e. became very rigid and
extended legs and arms."

Do you see that, Doctor?

A. Yes.

Q. And given what you have said
previously about the Inwood child and the temporal
relationship between administration of Lasix and
the terminal symptoms, does the note that I have
just read to you raise a question in your mind as
to whether or not that was in fact Lasix that Baby
Miller received?

A. Yes I think it would have to
in the context in which I am looking at these charts.

Q. Once again presumably had that



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been digoxin other than Lasix, Doctor, it would certainly account for the terminal events happening in the way they did.

THE COMMISSIONER: 6 milligrams IV push would that -

THE WITNESS: 6, well 6 milligrams of furosemide in this child would seem a reasonable dose if it were given as a diuretic. If it isn't furosemide I don't know what the dose is, you know.

THE COMMISSIONER: You know what the proper digoxin dose is?

THE WITNESS: Yes.

THE COMMISSIONER: But 6 milligrams I don't know what - I have religiously refrained from finding out what the quantity of the pediatric vial is, but perhaps I will have to so it will make some sense, what is the amount that is normally in a --

THE WITNESS: Digoxin?

THE COMMISSIONER: Yes.

THE WITNESS: Pediatric digoxin is supplied by Burroughs Welcome and is the only digoxin available in Canada as far as I am aware. It comes in a millilitre vial, labelled with green printing on the glass, it is .05 milligrams, .05



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milligrams.

Q. Mr. Commissioner, I think the vial itself is a millilitre?

A. That is right.

Q. The strength is .05?

A. .05 milligrams in that volume.

Q. So the volume of the vial itself is a millilitre?

A. Yes, a millilitre.

Q. And Doctor, are you familiar with the adult vial of naloxone?

A. An adult vial of naloxone is a 2 millilitre vial at a strength of .25 milligrams per millilitre, which is five times the concentration of the pediatric vial and since it contains 2 cc's it contains ten times the amount of drug that the pediatric vial contains.

THE COMMISSIONER: Yes, that I knew. When we speak of 6 milligrams.

MR. STRATHY: Millilitres.

THE COMMISSIONER: Millilitres, no, I am sorry the Lasix is --

THE WITNESS: Is 6 milligrams.

THE COMMISSIONER: The Lasix is 6 milligrams, so what would that be in the way of -



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THE WITNESS: Of volume?

3

THE COMMISSIONER: Yes.

4

5

THE WITNESS: I would have to check that. I know that the dosage is about a milligram per kilogram is what we use.

6

THE COMMISSIONER: Yes.

7

8

THE WITNESS: Which would be about the right dosage I suspect for this child.

9

10

THE COMMISSIONER: Yes. I am assuming it is digoxin for purposes of this exercise.

11

THE WITNESS: Yes.

12

13

THE COMMISSIONER: Supposing it were administered, 6 milligrams of the pediatric strength.

14

THE WITNESS: It would be furosemide.

15

THE COMMISSIONER: No pediatric digoxin.

16

THE WITNESS: Digoxin, yes.

17

THE COMMISSIONER: Instead.

18

THE WITNESS: Yes.

19

20

THE COMMISSIONER: What would the amount, what would be the effect of that? This is - now the IV push may have some effect because that would get it in faster than it ordinarily would go.

21

22

23

THE WITNESS: Yes I would like to check that, the volume in which 6 milligrams is

24

25



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contained to be sure I can answer your question
sensibly.

3

4

THE COMMISSIONER: Yes, all right.

5

A gram is obviously a unit of weight, and a litre
is a unit of volume.

6

THE WITNESS: Yes.

7

8

THE COMMISSIONER: I don't quite
understand why is Lasix measured by weight.

9

THE WITNESS : Milligrams?

10

THE COMMISSIONER: Yes.

11

THE WITNESS: Milligrams.

12

THE COMMISSIONER: Yes, but why,
why is it measured by weight instead of by volume?

13

14

THE WITNESS: Well I think it is
most usual to talk of drug concentrations, we give
so many milligrams of Lidocaine, or so many
milligrams of digoxin.

15

16

17

THE COMMISSIONER: Do you?

18

THE WITNESS: Yes.

19

20

THE COMMISSIONER: If you order, the
assorted orders that we have seen, doctors orders,
they are digoxin, they are not given are they in
milligrams?

21

22

A. They are given in micrograms.

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THE COMMISSIONER: Are they?

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THE WITNESS: They are given in micrograms because the digitalizing dose is --

THE COMMISSIONER: I shouldn't hold up while I am trying to understand this, and I think I can spend some time doing this. What I would like from you, sir, would be, if you can, to tell us what the effect would be if Lasix, this volume of Lasix were in fact digoxin?

THE WITNESS: Well I can only do that if I can look at a pediatric vial that is used and then translate the volume containing 6 milligrams into a volume of pediatric digoxin, and then I can give you the concentration of digoxin that might have been administered if in fact digoxin were being given instead of furosemide.

MR. STRATHY: I am not sure we can help you with that because I am not sure we have a pediatric vial of Lasix.

THE WITNESS: I will look it up.

Q. The point is, however, that Lasix of 6 milligrams was apparently given to the child by IV push. I put to you the proposition that if that was digoxin rather than Lasix it might account for the child going into an arrest. I think your answer fairly is that you can't say that unless



1
2 you know how much 6 milligrams of Lasix in terms
3 of vials translates into vials of digoxin?

4 A. I prefer to know what the
5 dosage of digoxin, if in fact it were digoxin,
6 that we are talking about. I might say that
7 seizing as a symptom of digitalis toxicity is
8 not something that is at all common. It could
9 occur as a complication of the cardiac arrest with
brain anoxia but not from digitalis.

10 Q. However, if digitalis was
11 administered at this point instead of Lasix, and
12 let us assume in a large intravenous dose?

13 A. Yes.

14 Q. Would it be fair to say that
15 that could certainly account for the child going
16 into the arrest in the way it did, whether that
seizing is common or not?

17 A. Yes, I would think so.

18 THE COMMISSIONER: I have no difficulty
19 with that proposition at all Mr. Strathy. The
20 difficulty I have, or at least what I would like
21 to know is whether - you see, they do give a
22 dosage of this Lasix, and presumably if they make
23 the mistake it is a double mistake, if the mistake -
24 first of all the substance and secondly they mistake
25



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the dosage. So if the dosage of digoxin can do no harm, obviously they can make the double mistake, but it makes a lot easier to understand the mistake if that particular volume administered -

6

THE WITNESS: Yes.

7

8

9

10

THE COMMISSIONER: In place of Lasix would have caused the death or would not have caused it, because we all know that this child, Miller, was on digoxin, was she not?

11

MR. STRATHY: Yes.

12

13

THE COMMISSIONER: So that there is no question of it doing her any harm if it is in a therapeutic quantity.

14

15

16

17

MR. STRATHY: Except for this, Mr. Commissioner, as I understand it most of these children were receiving oral digoxin in the usual course, and what we are talking about here is injecting a vial of digoxin in fact.

18

19

THE COMMISSIONER: Oh yes, then injecting it very fast.

20

21

MR. STRATHY: IV bolus.

22

THE COMMISSIONER: Yes.

23

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Q. Doctor, I am showing you a part of Exhibit 225 which is a vial of furosemide, I don't know whether that is a pediatric vial or



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not, can you assist us?

A. That is a reasonable IV dose, 20 milligrams is a reasonable IV dose for an adult 20 to 40 milligrams, and it is in 2 millilitres, it is 10 milligrams per millilitre. So if this were the vial -

Q. No, I just want to know, do you know whether this is an adult or pediatric vial?

A. I am not sure.

Q. All right, let's leave it at that, then.

A. I am not sure whether they make any other vials for children.

Q. I am sorry?

A. I don't know whether they make any other vials for children.

Q. And the vial I have just shown you is 20 milligrams per 2 millilitre vial?

A. Yes.

Q. Can I ask you to turn to Baby Janice Estrella, page 67 of your notes, please. Now there was not much discussion that I can see in the minutes of the meeting of September 13th concerning the Estrella child, apart from the observations on the second page of those minutes. The second page of



1
2 Exhibit 261, about three-quarters of the way down
3 is says:

4 "Sergeant Warr advised cases classified
5 as murder were Cook, Estrella, Miller
6 and Pacsai."

7 And it says:

8 "Mr. Cimbura stated that he had not
9 analyzed anything that shows overdose.
10 This is based on hospital analysis
11 and type of sample analyzed."

12 Do you understand that statement where it says:

13 "Mr. Cimbura stated he had not analyzed
14 anything that shows overdose."

15 A. No, I don't, I don't know
16 what he is talking about.

17 Q. Do you recall ---

18 THE COMMISSIONER: Did it not mean
19 he had not analyzed it, here are the results of it?

20 MR. STRATHY: I suppose that must be
21 what it means.

22 THE COMMISSIONER: I think he did in
23 one case, did he not analyze some of them?

24 MR. STRATHY: That leaves a question
25 in my mind.

THE COMMISSIONER: Mr. Olah has
a contribution I think.



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MR. OLAH: Yes, Mr. Commissioner,
you will recall one of the analyses was by Mr.
Cimbura?

MR. STRATHY: I am sorry?

THE COMMISSIONER: One of the analyses
on which Baby?

MR. OLAH: That was the Kristin
Inwood baby that was an analysis that was --

THE COMMISSIONER: Yes, you are
talking here about Cook, Estrella, Miller and
Pacsai?

MR. OLAH: I am sorry, I apologize,
we are talking only about those four?

THE COMMISSIONER: Yes, just those
four, yes. I thought the Pacsai child but I may
be wrong.

MR. STRATHY: Also in Estrella, I think
the problem is that it is ambiguous, I suppose it
is capable of the interpretation that Mr. Cimbura
had not analyzed anything, or that he had analyzed
some things but they didn't show over this, that
is what gives me trouble.

THE COMMISSIONER: Yes, Mr. Olah.

MR. OLAH: I had some concerns about
this too because he seems to be talking about all his



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analyses.

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THE COMMISSIONER: I don't think -
well I don't, that can't be right because -

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MR. OLAH: "Mr. Cimbura stated he had
not analyzed anything that shows an
overdose."

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And obviously that has got to be an error because of
Inwood.

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THE COMMISSIONER: Inwood is an
example because he certainly did analyze it, and
I think he did some anyway.

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MR. STRATHY: His report Exhibit 94
mentions analysis and things from Estrella,
for example.

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THE COMMISSIONER: Of the analysis
of blood?

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MR. STRATHY: No heart.

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MS. CRONK: Fixed tissues, sir.

THE COMMISSIONER: You see tissues
won't show overdose, you see, and that is probably
what he means.

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MR. STRATHY: Well, that may well be.

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THE COMMISSIONER: Nothing he
analyzed would show an overdose, but I don't think
that is true I think it is Pacsai.

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MS. CRONK: The matter is further complicated, sir, because you will recall that in Justin Cook he did do tests on blood samples and the levels you will recall were high, and you are quite right that is true in Kevin Pacsai.

THE COMMISSIONER: Well in any event, Doctor, I think you might have been asked about this before but do you recall that there was much discussion at all at the meeting concerning those four cases classified as "murder"?

THE WITNESS: I don't think so.



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Q. And the only question I want to ask you about Estrella is in relation to the question of the reliability of the post mortem digoxin level of 72 nanograms per millilitre which you have noted at the bottom of page 68.

A. Yes.

Q. And I think there was a reference in your evidence in chief to the expression "gutter blood". Do you remember that?

A. Yes, I remember gutter blood being used.

Q. Do you recall Mr. Cimbura using that expression in relation to this child Estrella?

A. I recall the term "gutter blood" being used and I can't remember in relation to which child it was used. No, I can't remember.

Q. Do you remember that it was used by Mr. Cimbura?

A. Oh, yes, I think so, yes.

Q. And was it used by him in the context of suggesting there may be some question in the interpretation of gutter blood samples?

A. Oh, I think that is true, yes.

Q. If you would turn to Baby Taylor --



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A. Excuse me, may I just make one comment about that before you leave?

Q. Yes.

A. I don't know when this gutter blood came up in the context of my analysis of the chart and the level which I have recorded here on page 68. And as I said yesterday I believe, or the day before, the arrhythmia plus the high, as I take it, post mortem serum digoxin level of 72 nanograms per millilitre were the reasons for my putting this child into the category in which I placed her.

THE COMMISSIONER: What category did you place her because all you said in your report was that this child's death was attributable to digitalis at the meeting at the Hospital for Sick Children in September, 1982, but I take it that you concurred in that.

THE WITNESS: Yes, yes, I did.

MR. STRATHY: Just for the record the witness' note on the child has an "A".

THE WITNESS: Yes.

THE COMMISSIONER: And you think you put that on before you --

THE WITNESS: Yes, I think so, yes. Mind you now having gone this length of time and



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with the further evidence of the toxicologists I don't know just how much weight I put on that. But, you know, that sounds very high to me. Very high. 72 nanograms per millilitre.

MR. STRATHY: Q. Well, you say "very high". Yes, it is very high, but does that suggest to you there was a problem with the sample or are you suggesting the very high causes questions in your mind?

A. Well, of course it causes a question that I have been asked to address.

Q. Well, I'm sorry, you started out by saying that looking back on the question today that you might have doubts about putting it in an A and I understood --

A. Well, if you put me right against the corner and say "Where are you going to put it today?", I will put it right in A again because I still think that is high, but you talk about gutter blood and you talk about things that really I am not an expert in, but it sounds high to me.

Q. Based on the evidence that you see?

A. Yes.

Q. And the evidence you see is



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that 72 level?

A. Yes.

Q. And I think it would go almost without saying, Doctor, that if you were satisfied that there was a serious question about that 72 level as to whether it is reliable or not you would have a serious question about your A?

A. Yes. I don't think there is anything inconsistent in that view.

Q. No, I am not suggesting that it is. I think that would be reasonable, Doctor, to change your mind --

A. Yes.

Q. -- if you were shown that the evidence on which you based your opinion was questioned.

A. Yes.

Q. Could you move then to Baby Taylor, please, at page 9 of your notes? And just on page 9 at the top under "Anatomic Diagnosis" you have severe aortic stenosis, EFE, endocardial fibroelastosis.

A. Yes.

Q. What is LALV?

A. Left atrium and left ventricle.



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Q. And then underneath?

A. Congenital mitral stenosis.

Q. Patent ductus arteriosus?

A. Persistent ductus arteriosus.

Q. LVH?

A. Left ventricle hypertrophy.

Q. Right ventricle hypertrophy?

A. Right ventricle hypertrophy.

Q. Congestive heart failure?

A. Yes.

Q. And as I understand it,

Doctor, that anatomic diagnosis indicates a very serious and severe heart disease?

A. Yes. These babies die often within the first few weeks of life.

Q. So it would be fair to put this child Taylor also in the category of being at high risk of dying?

A. Oh, yes. From the heart disease, yes.

Q. And you have got at the top of the page "Autopsy" and then three stars beside it.. Do you know what that means?

A. Yes. I was most impressed - I have come to this before - by Dr. Ted Izukawa's



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notes that I read with some considerable interest,
and he knows it - I think this is all Dr. Izukawa's
notes that I have here, heart rhythm - heart rate
variable rhythm irregular rhythm strip sinus
tachycardia; the PR interval is long --

Q. Just before you come to
Dr. Izukawa's notes because I was going to ask you
about that.

A. Yes.

Q. My question is in relation
to autopsy and why you had those three stars there.
Were those three stars in relation to the autopsy?

A. Oh, no, no, no.

Q. Do you know why you put
"autopsy" there? Was that just to show --

A. I often write "autopsy"; just
a note that I had seen the autopsy report.

Q. If I indicated to you that the
autopsy - it has been said that the autopsy findings
indicated that the child's condition was even more
severe than they thought in a clinical setting,
I take it you would agree with me that that would
certainly explain the child dying when he did and
in the way he did?

A. It doesn't have to be any more



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severe than I have got here.

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Q. That could certainly account

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for it?

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A. Yes.

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Q. Then let me ask you about

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Dr. Izukawa's notes. You said in your evidence that
you were influenced --

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A. Yes.

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Q. -- by the note of Dr. Izukawa.

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A. Yes.

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Q. And then Miss Cronk read you

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Dr. Izukawa's evidence yesterday and you said on the
basis of hearing Dr. Izukawa's explanation that you
would have to move the child down to very low
suspicion. Do you recall that?

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A. Did I say that?

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THE COMMISSIONER: I'm afraid - no,

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I think that was --

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MR. STRATHY: I'm sorry. I'm sorry.

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MS. CRONK: I don't think that is

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what the doctor said.

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MR. STRATHY: Excuse me, you are

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quite right.

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My note on your evidence is you must

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now say that your suspicion is very low as a result

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of hearing Dr. Izukawa's evidence.

THE COMMISSIONER: Well --

THE WITNESS: Oh, no, no.

THE COMMISSIONER: I am not even
sure that that --

THE WITNESS: It is Dr. Freedom
that you may be thinking about. I said that about
Dr. Freedom.

MS. CRONK: My understanding of
Dr. Fay's evidence yesterday was that with the
benefit of hearing Dr. Izukawa's evidence he would
still on the face of the note and in the context of
the time it was made have concerns.

THE WITNESS: You see Dr. Freedom
stated something completely different. He said he
wasn't referring to the child that I thought he
was referring to.

MR. STRATHY: Just give me a moment,
Doctor, please.

MS. CRONK: Page 4866,
Mr. Commissioner, Mr. Strathy.

MR. STRATHY: This is Taylor?

MS. CRONK: Yes, and the question
was after I read the passage:

"Dr. Fay, I appreciate that Dr. Izukawa's



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3 "views with respect to the note that
4 he had made and the action he took
5 were previously not available to you,
6 but now being informed as to what
7 Dr. Izukawa's evidence was in that
8 regard, does his evidence in any way
9 affect your opinion as to the possible
10 involvement of digoxin intoxication in
11 the death of this child?

12 A. I would have expected Dr. Izukawa,
13 being the physician that he is, to
14 have done precisely what he did and
15 I think in his position I would hope
16 that I would have done the same and
17 I think I would have come to the same
18 conclusion.

19 I can only repeat that I am looking at
20 this from a different point of view
21 and, with all due respect to Dr. Izukawa,
22 I cannot then take that as evidence
23 that there was no digitalis intoxica-
24 tion. It is completely impossible for
25 me to adopt that task because I found
in none of these charts any evidence
of digitalis overdosage in the dosages



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He continues:

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"that were recorded and was recorded
as given to the infant in the orders."

"Although...(Dr. Izukawa) has done
exactly what I would have expected
him to do, I cannot remove entirely
suspicion because Dr. Izukawa was
suspicious, he felt at the time that
he had reviewed things and that there-
fore he attributed the arrhythmia,
the death to the child's serious
congenital heart disease, which may
have been the case, of course. But
I cannot say that I can do away with
all suspicion in the setting in which
I am asked to look at the chart from
the point of view of whether digitalis
was a factor in the child's death."

MR. STRATHY: All right. I think
that is - thank you for reading that, Miss Cronk.

Q. You say there, Doctor, you
can't do away with all suspicion.

What I want to ask you this: on your
card you rank this child as four rankings on this
card. It has suspicious with an arrow upwards;



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2 it has probable that has been crossed out; it has
3 B+ and it has got a A.

4 A. Well, that's all right. A is
5 obviously my original - I think my original categori-
6 zation and I must have downgraded it somewhat after
7 discussion. I was very influenced by this final note.

8 Q. Well having heard Miss Cronk
9 yesterday read to you what Dr. Izukawa said about
10 this child would you agree with me that your suspicion
11 would go from a high suspicion to a low suspicion?

12 A. I am having one difficulty,
13 Mr. Commissioner, with these hearings, and I don't
14 seem to be able to get over two people the scenario,
15 but perhaps I should paint it for them.

16 Q. Well, just --

17 THE COMMISSIONER: Well I think we
18 understand that. It really isn't that. The question
19 that is put to you now --

20 THE WITNESS: Yes.

21 THE COMMISSIONER: -- is quite a
22 simple question now having heard what Dr. Izukawa
23 said, having had that read to you, does it now affect
24 you now - don't worry about the hearing - does it
25 now affect you so that you might change your position
which you had at the hearings. That is all the



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question is.

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THE WITNESS: The position that I had?

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THE COMMISSIONER: At the hearing.

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We understand your position at the hearing that it

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was --

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MS. CRONK: At the meeting.

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THE COMMISSIONER: Sorry, at the

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meetings. Well, I guess this too early on Thursday

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is not a good idea. But does it now affect you or

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does it not? And either answer is appropriate but

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just give us what the factors are. Does it or doesn't
it?

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THE WITNESS: I understand by what

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I said originally, Mr. Commissioner.

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THE COMMISSIONER: Yes.

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MR. STRATHY: Q. I'm sorry, are you

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saying then that what you heard of Dr. Izukawa's

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explanation has not changed your view of the child?

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A. It cannot in the position in

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which I am reviewing this situation. It cannot change
it.

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Q. Well, I am asking you, Doctor,

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not to look - not to give us the opinion you gave at

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the meeting of September 13th.

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A. Yes.

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3 Q. But to give us the opinion
4 based on what you now know about the child and one
5 of the things you now know is that you have an
6 explanation by Dr. Izukawa for his note. And what
7 I take from Dr. Izukawa's explanation is that he did
8 not have concern about the child dying as a result
9 of digitalis.

10 THE COMMISSIONER: After he had
11 examined the --

12 MR. STRATHY: Yes, after he examined
13 the dosages that the child had had.

14 THE COMMISSIONER: Yes.

15 MR. STRATHY: Q. And knowing that,
16 Doctor, knowing the context in which Dr. Izukawa made
17 that note, I am asking you whether you still have
18 the same concern you initially read the chart without
19 the benefit of Dr. Izukawa's interpretation of it
20 or explanation?

21 A. Yes, for the simple reason that
22 I wouldn't know in Dr. Izukawa's position just how
23 much digitalis the child had received.

24 I could read what it is supposed to
25 have received. I could know that it had terribly
serious heart disease and might die this way, and I
might and almost certainly would have in his position



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2 have done what he did. But he didn't know - he
3 couldn't with absolute certainty how much digitalis
4 the child had received.

5 Q. Well, Doctor, we can't know
6 that in the case of any child, can we?

7 A. Well, that is right.

8 Q. And in this particular case
9 of Taylor as you note on your notes there was
10 absolutely no toxicology on the child.

11 A. No.

12 Q. No toxicology information at all.

13 A. No.

14 Q. And you have told us that there
15 are good reasons from the child's clinical condition --

16 A. Yes.

17 Q. -- that he might have died
18 exactly the way he did?

19 A. Yes, that is true.

20 Q. And the only thing that you
21 can point to that causes you any suspicion at all
22 is this note of Dr. Izukawa.

23 A. Yes.

24 Q. Isn't that fair?

25 A. Yes, that is right.

Q. And Dr. Izukawa has told us that



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2 he in retrospect and having reviewed the dosages is
3 satisfied, has satisfactory explanation for the child's
4 death?

5 A. Well, I respect that opinion,
6 but it isn't my opinion that I can sit here now and
7 say, no, there is no possibility of digitalis
8 intoxication.

9 Q. No, I am not asking you to say
10 that whether there is no possibility, but what I am
11 asking you and I am enquiring is whether or not --

12 A. Yes.

13 Q. -- your opinion is on the
14 high side of suspicion or on the low side of
15 suspicion, and I suggest to you there is no evidence
16 other than Dr. Izukawa's statement that would cause
17 you to place it on the high side of suspicion?
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2 A. Well, I will place it on the
3 low side of suspicion all right but I have to
4 retain what I said before that in this situation,
5 allowing that I agree with everything Dr. Izukawa
6 said, allowing that the child had very severe
7 congenital heart disease, allowing that the child
8 could have died at any time, and they do die earlier,
9 I, in my position, would have to hold to what I have
10 already said and for the reasons I have already
11 stated.

12 Q. Just so we know, Doctor,
13 today, I want to know whether you are putting this
14 child, today, on the high side of suspicion or the
15 low side of suspicion?

16 A. Low.

17 Q. Thank you. Could I ask you
18 to move to Baby Gage, please?

19 A. Which page is that?

20 Q. I am sorry, page 37 of your
21 notes. I am afraid I just can't read your writing.
22 You've got your diagnosis at page 38 "Anatomic",
23 could you interpret that for us, what that writing
24 means, "T.G.A."

25 A. You mean you can't read my
writing! Transposition of great arteries, post



1
2 atrial septostomy. That is an opening of the
3 partition between the upper chambers, persistent
4 ductus arteriosus, papillary muscle infarction
5 of the whole right ventricle, that is a death
6 of the muscle which holds the guidelines that
7 attach to the valve, in this case the tricuspid
8 leaflet edges in the right ventricle that prevent
9 the right ventricle pumping back into the right
10 atrium. I am sure Dr. Rowe has explained all of
11 this.

11 Q. Yes.

12 A. And pulmonary congestion,
13 presumably on the basis of heart failure.

14 Q. And would you describe those
15 findings as indicative of severe congenital heart
16 disease?

16 A. Yes, very much so.

17 Q. And would those anatomical
18 findings account for the child dying the way he
19 did?

20 A. Could do, could do.

21 Q. When he did?

22 A. Yes.

23 Q. Doctor, Laura Woodcock is the
24 next child and that is at page 1 of your notes and
25



1
2 the minutes it is page 232.

3 A. Yes.

4 Q. You have placed this child
5 in a possible category and your yellow card says
6 B minus, possible low suspicion with an arrow
7 going down. My recollection of your evidence
8 yesterday, at least my note of it, is that you would -
9 your opinion was that the child most likely died of
her disease?

10 A. I think so, yes.

11 Q. And what I want to ask you,
12 Doctor, is that in the minutes at page 232 at the
13 bottom of the page, five lines up we have Mr.
Cimbura giving his views and it says:

14 "Mr. Cimbura gave the toxicology
15 report on an exhumed muscle specimen
16 revealing a small amount of digoxin ..."

17 Do you see that?

18 A. No.

19 Q. I am sorry, page 232?

20 A. 232, yes.

21 Q. Under Laura Woodcock, third
22 paragraph under Laura Woodcock.

23 A. Yes.

24 Q. "Mr. Cimbura gave the toxicology
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"report on an exhumed muscle specimen revealing a small amount of digoxin -- trace with value of about 4. He said that the last known dose was four days before death, and with this finding there was no suggestion of overdose."

My question really is, given your views on the child's clinical condition, given that Mr. Cimbura's toxicology evidence appears to indicate that there was no concern about an overdose, would you not be inclined to move Laura Woodcock into the natural category?

A . Yes, I would do that.

Q. Yes. And, Doctor, Baby Velasquez. I am sorry, I wonder if we could have the chart for Velasquez, Mr. Registrar.

Velasquez is at page 31 of your book.

A. Yes.

Q. Page 237 of the minutes. You have low suspicion on your card?

A. Yes.

Q. B, low suspicion, and then the minutes of the meeting, page 237, as I think has already been mentioned, the second paragraph under



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Velasquez on page 237 it says:

"Dr. Fay referred to the chart;
heart disease of some magnitude;
given too much codeine. Dr. Fay
said he would almost be inclined to
put this into Natural Category."

A. Yes.

Q. First of all, Doctor, do you
recall expressing that opinion at that meeting?

A. Oh, I think so. I can't
really recall in detail but I think that is
correct.

Q. And I think I am being fair
to the evidence when I say that there had been a
theory put forward, and I think Miss Cronk mentioned
it to you, that the child died because of an
idiosyncratic reaction to the naloxone?

A. Yes.

Q. And one of the explanations,
or one of the pieces of evidence offered in support
of that theory was the temporal relationship between
the naloxone administration and the death?

A. Yes.

Q. Is that something in your
view which would give credence to that theory?



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A. Oh, yes, I think so, yes.

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Q. Now, another piece of evidence

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that has been offered in support of that theory is

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the fact that after the first injection of naloxone

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the child appeared to respond?

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A. Yes.

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Q. And it had been suggested by

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at least one witness, and I believe more, that had

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the child been suffering from a digoxin overdose

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you would not have had that favourable response

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to the first dose of naloxone. Are you prepared

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to accept that?

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THE COMMISSIONER: I am sorry, had

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he been suffering from ...?

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MR. STRATHY: Had he been suffering

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from digoxin overdose at the time.

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THE COMMISSIONER: That wasn't the

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way I understood it.

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MR. STRATHY: Well, that's the way ---

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THE COMMISSIONER: Perhaps you are

22

right.

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MR. STRATHY: I think it is Dr. Rowe

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as a matter of fact.

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THE COMMISSIONER: Dr. Bain I thought.

MR. STRATHY: Dr. Rowe.



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MS. CRONK: Rose or Rowe?

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MR. STRATHY: Rowe.

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THE COMMISSIONER: Well, maybe,
maybe.

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MR. STRATHY: That had the child been
suffering from digoxin toxicity at the time as a
result of the administration of the digoxin.

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THE COMMISSIONER: Well, maybe that
was put too. It was also put at one point, strange
that he reacted favourably to the first overdose,
first dose, which was an overdose and yet the
second one killed him.

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MR. STRATHY: Quite so.

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Q. Well, let me put my question
again, Doctor. If you take it from me that there
has been evidence that one piece of evidence in
support of the idiosyncratic reaction to the
naloxone theory is the fact that the child initially
responded to the naloxone, and that is in the chart?

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A. Yes.

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Q. Suggests that at the time the
child was not suffering from digoxin intoxication.
Is that something that you are prepared to go
along with or can you say?

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A. Well, I can certainly say that

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somnolence and hypothermia pinpoint pupils are not signs of digitalis overdoses but overdosage but they are certainly signs of codeine effect.

Q. That was going to be one of my questions.

A. Yes.

THE COMMISSIONER: May I have that, please.

MR. STRATHY: But you anticipated me.

THE COMMISSIONER: What did you say?

THE WITNESS: That the symptoms that I have written down here, Baby somnolent, hypothermic with pinpoint pupils are not signs of digitalis overdosage.

MR. STRATHY: And those were the symptoms -- just wait for a moment.

THE COMMISSIONER: Where have I got that from?

MR. STRATHY: Yes, the chart.

THE COMMISSIONER: Yes, at page 32?

THE WITNESS: Page 32, yes, of my notes.

MR. STRATHY: Q. Do you have the Velasquez chart in front of you?

A. Yes.



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Q.. Let's see if I can find it.

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The reference is at page 29 of the chart.

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A. Yes.

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Q. Developed bradyarrhythmia
somnolence and small pupils.

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A. Yes.

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Q. These are the nurse's notes
I believe.

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A. Yes.

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Q. No, excuse me, they are Dr.
Costigan's notes.

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A. Yes.

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THE COMMISSIONER: Page?

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MR. STRATHY: Q. 29, I believe,
Doctor. Can you see the upper right-hand corner?

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A. 29.

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THE COMMISSIONER: Yes, all right.

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MR. STRATHY: Q. Doctor, I take it
that then those symptoms that you see, that you
have referred to, are signs of codeine?

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A. Consistent with codeine.

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Q. But not consistent with
digoxin toxicity?

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A. No, I wouldn't have said so.

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Q. And would you agree with the

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proposition that I put to you initially, that is,
that had the child been suffering from digoxin
toxicity, there would not have been that response,
the initial response at least, to the narcan?

A. Oh, no, the child is
responding appropriately to the effects of the
naloxone.

THE COMMISSIONER: Effects of the
codeine.

MR. STRATHY: No, of the antedote
in effect.

THE WITNESS: Yes.

Q. But that favourable response
would not have occurred if what was happening was
digoxin toxicity?

A. No. Well, we didn't think it
was digoxin toxicity.

THE COMMISSIONER: No, I am sorry.
The child received codeine at some point?

THE WITNESS: Yes.

THE COMMISSIONER: And having appeared
to have suffered from too much codeine?

THE WITNESS: Yes.

THE COMMISSIONER: Or an adverse
reaction he was given naloxone?



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THE WITNESS: Yes.

THE COMMISSIONER: And you are saying?

THE WITNESS: Responded appropriately.

THE COMMISSIONER: Responded. But
the question that was put to you was, could the
child, if the child was suffering not only from
codeine but also from digoxin toxicity at that
time, could he have responded satisfactorily to
the naloxone?

THE WITNESS: Yes, he would have
responded to the naloxone. I would have expected
him to respond to the naloxone. The signs of
ditigalis toxicity would have been, in my opinion,
to do with arrhythmias maybe.

THE COMMISSIONER: Yes, but I am not
too sure you understand the question that was put
to you by Mr. Strathy.

THE WITNESS: I am sorry.

THE COMMISSIONER: Let us assume
first of all that he has had too much codeine and,
secondly, had too much digoxin.

THE WITNESS: Yes.

THE COMMISSIONER: Now, the codeine
affects him in a certain way.

THE WITNESS: Yes.



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THE COMMISSIONER: Naloxone is the
remedy for that?

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THE WITNESS: Yes.

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THE COMMISSIONER: Now, if he is
suffering from both, an excess codeine and an excess
of digoxin, would he have responded as he did to
the first dose of naloxone. I think that is your
question but I may be wrong.

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MR. STRATHY: Well, it is the second
question and actually, it is not my question.

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THE COMMISSIONER: Oh well, all right.

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MR. STRATHY: No, I think the witness
should answer your question and then I will put my
question.

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THE COMMISSIONER: Yes, all right.

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THE WITNESS: Yes, I think he would
have responded. I don't think the response completely
rules out the possibility of digitalis toxicity,
no.

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THE COMMISSIONER: Yes, all right.

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MR. STRATHY: Q. May I put now another
possibility to you, Doctor, and that is this.

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Q. Suppose the child was not
suffering from codeine toxicity?

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A. Yes.



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Q. Or excess codeine?

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A. Yes.

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Q. But was simply suffering from digoxin toxicity?

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A. Yes, yes, I understand.

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Q. Now, you have already told us that you didn't think the symptoms are consistent.

8

A. Yes, I understand.

9

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Q. But just suppose all that was troubling the child was digoxin?

11

A. Was digoxin.

12

Q. Would you expect the narkan to work in those circumstances?

13

A. No, no, not at all.

14

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Q. Well, I think that is what the evidence of the other witnesses has been and I think you are in agreement with them. Do you understand, Mr. Commissioner, I think that is more important.

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THE COMMISSIONER: Well, I think I understand, yes.

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Yes, all right, thank you.

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We started early, how close are you to finishing?

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MR. STRATHY: Pretty close to the end. The only thing I was looking for was a note

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(Strathy)

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as to his evidence with respect to Velasquez

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but I will try and put it, what I understood his

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evidence to be.

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THE COMMISSIONER: My understanding of it was you could not rule out either Naloxone or digitalis toxicity, but if he had to choose between the two of them he would choose Naloxone.

MR. STRATHY: I think that is with respect, that is a fair statement of your evidence, Doctor.

THE COMMISSIONER: It still presumably could be something else entirely, could it not?

THE WITNESS: Well, --

THE COMMISSIONER: Something different from either of them?

THE WITNESS: I think it is difficult in this case, Mr. Commissioner, you see, as I said yesterday I thought from the anatomic findings that the child might have been in the worst degree of congestion and in fact the child was according to what Dr. Rowe stated, unless I misunderstood. I really from my notes thought the child was in perhaps a worse degree of failure then.

THE COMMISSIONER: He may well be, but they were going to send him home, this is a very strange result, from the hospital, they didn't understand what happened.



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2 THE WITNESS: He clearly wasn't in--
3 I only had the autopsy findings.

4 THE COMMISSIONER: Yes.

5 MR. STRATHY: Q. I think the
6 Commissioner has stated your evidence, Doctor, as
7 it was given yesterday in response to a question by
8 the Commissioner when you were asked would you put
9 the two on an equal basis, and as I understood your
10 bottom line is you would put Naloxone as the more
11 likely?

12 A. That is correct.

13 Q. May I assume that is because
14 of the evidence that you see with respect to the
15 temporal relationship?

16 A. Yes, I think so, I think it
17 has to be.

18 Q. May I ask you, Doctor,
19 presumably in coming to opinions in these matters --

20 A. Yes.

21 Q. Just like a judge, you
22 look for evidence, don't you?

23 A. Yes.

24 Q. And you are only giving an
25 opinion based on the evidence that you see before
you.



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A. Yes, that is right.

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Q. As we have said before, your opinion obviously is only as good as the evidence that is presented to you.

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A. Yes.

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Q. May I ask you what evidence you see in the case of Velasquez that would lead you to a conclusion of digoxin toxicity, or would permit anyone to come to a conclusion as to digoxin toxicity, where there is no toxological evidence or information concerning the child?

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A. I think you remember my comments yesterday, that I said that once we entered the categories four and five, we entered a grey area, and I think that is everything from light grey to off-white. So it wouldn't worry me to put baby Velasquez into natural causes, to drug reaction I mean, that we know --

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Q. Natural cause is drug reaction?

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A. I'm sorry, not natural causes, that we now have an explanation that I would accept, not natural causes, but I mean into -- we are talking of suspicion of digitalis and I would take it out of that category.



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Q. So in effect you would really go back to the view you originally expressed at the meeting?

A. I think so, yes.

MR. STRATHY: Thank you. Thank you, Doctor.

THE COMMISSIONER: I think we would take 20 minutes now. You will be quite some time, I suspect, will you not?

MR. ROLAND: Well, I think I may be somewhat shorter than my estimate yesterday, but I will be a while.

THE COMMISSIONER: I think we will start you after 20 minutes from now, there always seems to be a question, what time does that clock say, we will go by that clock, seven and a half minutes past, then 27 and-a-half we will be back.

---Short recess.

---Upon resuming.

THE COMMISSIONER: Yes, Mr. Young.

MR. YOUNG: I have a number of things to report on this morning.

THE COMMISSIONER: Yes, all right.

MR. YOUNG: I have investigated



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most of them and I have the following to tell you.
First of all, as has already been revealed we have
found the original index cards and foolscap that
Dr. Fay has prepared and we turned them over to
Commission counsel to examine.

MR. COMMISSIONER: Yes.

MR. YOUNG: And also the police did
in fact visit all of the parents, I should say
that in some instances some of the parents lived
out of the country and were a long ways away for
this visit. The parents were visited where possible,
and the deaths of their children were discussed. It
was only in the cases where the police were convinced
death was as a result of natural causes that any
conclusion was given to the parents.

Finally, Mr. Commissioner, I believe
Tuesday of this week there was some suggestion
that Page 156 of the Estrella chart, which is
Exhibit 91, and on that page there is an inscription
that says, "Leg milked for purposes of gutter blood".

MR. COMMISSIONER: Yes.

MR. YOUNG: We at one point thought this
might have been written, the writing of a police
officer. I think we may have given that information
to Ms. Cronk and I indeed rose the other day to



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2 confirm that. Upon further review we are not certain
3 in that we can't identify which of these officers
4 that would be and we are now somewhat doubtful that
5 it was indeed a police officer who wrote that.
6 It might have been Dr. Hastreiter and I will put
7 that question to him, and I can't help you with the
8 time that it was added to this chart. We will make
9 further inquiries, but at this time I really don't
10 have much to tell you about that.

11 MR. COMMISSIONER: Yes, all right.

12 MR. YOUNG: Thank you very much,
13 Mr. Commissioner.

14 MR. COMMISSIONER: Now, we are
15 going to have some timing problems as I understand
16 that Dr. Fay was at least tentatively booked on
17 the train tonight.

18 THE WITNESS: Yes.

19 MR. COMMISSIONER: Was that at
20 5:30?

21 THE WITNESS: Yes.

22 MR. COMMISSIONER: That means we
23 have to stop at five. I take it you can check out
24 of the hotel and that sort of thing at noon and be
25 ready to go.

THE WITNESS: My wife is with me and



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has checked out, that is no problem.

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MR. COMMISSIONER: So I would like to just do something, perhaps we will let you go through and we will worry about the timing after.

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MR. ROLAND: I will try to cut it down as much as I can.

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MR. COMMISSIONER: Yes, all right.
CROSS-EXAMINATION BY MR. ROLAND:

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Q. Dr. Fay, in order to deal with the setting of your review and you have told us repeatedly about the setting of your review, and you have reminded us of it in many of your answers to the questions and to put them in the context of the setting of your review of the charts.

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You have told us basically that the setting of the review is in the context of the preliminary inquiry of Susan Nelles on the charges of four murders, for which she was discharged, and the murders that she had been charged with were with respect to Babies Estrella, Pacsai, Miller and Cook. That there was ongoing police and coroner investigation after the discharge of Susan Nelles, and it was concluded by everybody, I take it from the outset of your review, that there were at least four murders,



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2 that was the presumption you were operating on, is
3 that fair?

4 A. I think that is correct,
5 yes.

6 Q. So it wasn't a question of
7 deciding whether or not there was a murderer, and
8 indeed it wasn't a question of deciding whether there
9 was a murder weapon on your part, what the issue was
10 for you I gather in the chart review was to examine
11 the charts of other babies; and you also examined
12 the charts of those four babies, Estrella, Pacsai,
13 Miller and Cook?

14 A. Yes.

15 Q. But you went beyond that to
16 examine the charts of other babies to determine how
17 broadly the murder net could be cast.

18 A. Yes, I suppose basically that's
19 it. When I was asked by the Chief Coroner to do
20 this I understood that he wished me to review a
21 number of charts and I did more charts than we have
22 here; review a number of charts to determine whether
23 digitalis overdosage was instrumental in causing --
24 in the child's death.

25 Q. Yes. As you have told us,
that is in the context of the presumption of murder in



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at least four babies.

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A. Oh, I think so, yes.

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Q. And the presumption that the murder weapon is digoxin?

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A. Yes.

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Q. So in terms of your examination of the charts then I take it what you have told us you were not examining the charts for the purpose of determining the cause of death, or the most likely cause of death, you were trying to determine from your review of the charts rather how likely digoxin overdose could be the cause of death.

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A. That's it, yes.

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Q. And I gather from what you have told us in the review of the charts that you concluded a number of things. You concluded first of all that there was no indication in any of the charts that there was a prescribed overdosage of digoxin that could have led to the deaths of any of the babies.

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A. In none of the charts that I examined was that the case.

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Q. The second thing you have told us I gather now in reflection on your review, is that there was very little indication in the charts themselves, set aside the toxicology, the charts

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themselves, that would lead you to a serious suspicion of digoxin causing the deaths by overdose of any of these babies, setting aside the toxicology.

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A. I think that is true, too.

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Q. And so in the end when you come down to selecting your eight or so probable or most likely candidates for suspicious death, you are relying I gather first and foremost on the toxicological information you have been given and taking it, and you take it at face value with the numbers that you are given.

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A. Yes. Really I am, yes, because I looked at the child and it was an arrhythmia which could have been caused by digitalis, then I get the toxicology and sometimes we are not absolutely certain what to make of that. Sometimes it seems that there was indeed a very high concentration and putting those together that is really all I am working with basically.

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Q. Is the toxicological information?

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A. Yes.

Q. And the bald numbers that you are provided?

A. Yes.



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Q. And as I understand it, Doctor, what you have told us there was very little discussion or analysis of the implications of those numbers; there was Mr. Cimbura suggesting that the numbers may not in one case or another be satisfactory to draw a quantitative conclusion, but there was little detailed sort of analysis in the discussions about the problems, the underlying problems associated with analyzing those numbers.

A. To the best of my recollection, the meetings at the police headquarters were attended by Mr. Cimbura, he may not have been there on one occasion, but I think he was there on however many it was, four or five, he was there and probably all but one and that can be checked of course. There was talk about toxicology at those meetings. The only meeting where we really got down to considering the whole group which is here represented, was at that meeting on the 13th of September and then we had Mr. Cimbura present and we had, as you see from the minutes, comments and figures.

Q. Yes.

A. On the toxicology at that time, some I already have, some I had obtained presumably from those meetings, but I don't think



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2 very much; some I had obtained from the docket in
3 the large envelope in which the chart was contained,
4 that is the police envelope, I call it, but it was
5 in that chart contained and that is where
6 I got my information.

7 Q. And at the time of your
8 chart review and at the time of the meeting of
9 September 13th, I take it you were equating the
10 numbers that were given for digoxin concentration
11 in post mortem samples, whether they were serum or
12 tissue, you were equating those numbers with your
13 knowledge of ante mortem levels that are either
14 in the therapeutic range or beyond the therapeutic
15 range, you were not making any other assumptions
16 but an equation between those two.

17 A. I wasn't really in a position
18 to even make that assumption in many cases, because
19 even Mr. Cimbura didn't know what that level per
20 gram really meant as a level during life, particularly
21 with the exhumed babies. Certain figures I did take,
22 such as that 72 nanograms and there again there is
23 this whole question of gutter blood and I really
24 cannot, not being a toxicologist or a pathologist,
25 truthfully comment on that it sounds high to me as
a clinician.



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Q. Let's deal with that one for instance, that is not a tissue sample that is a fluid sample?

A. Yes.

Q. There was some debate about the quality of that fluid; whether it is blood or gutter blood or what it is, but it is a fluid sample; and I take it when you heard the number 72 you equated that with the therapeutic range but that you knew was accepted for digoxin which was in the range of 1 to 2.5 or 3.

A. Well, basically that is correct. Mind you, by this time I was already learning more about digoxin from pharmacokinetics and what happens post mortem and leaching from the myocardium and so forth.



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But basically I was relying on the toxicology and
the opinions as expressed by Mr. Cimbura.

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Q. Let me ask you about the
numbers a little further because we have heard
evidence and it now seems to be understood, although
I don't know how clearly it was understood nearly a
year ago, it now seems to be understood and generally
accepted by the experts who have come to testify at
this inquiry that there is a multiplier factor
between ante mortem digoxin levels in serum and
post mortem levels, and that has been expressed as
a range -- it can range in the extremes from almost
the same up to, I think, 5 or 6 and we have seen
some even higher, but the general average and the
accepted range, I think, is 2 to 4.

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A. I see.

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Q. Something like that, 2, 3, 4.

I take it that is not something you were applying
to these figures that you were given, even the 72
figure, even then during that meeting. That isn't
something you were aware of at the time.

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A. No, I didn't. We weren't
applying any multiplier factor. There was no figure
that was being used to multiply anything.

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Q. Yes.



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2 A. Or divide anything. But we
3 certainly had from Mr. Cimbura's comments and
4 information that there were factors affecting
5 post mortem serum levels taken from, say, the
6 heart; there was a leaching from the myocardium
7 after death but no factor was talked of or mentioned
8 as far as I can remember.

9 It was perfectly obvious that the
10 tissues of the exhumed babies when subject to analysis
11 in terms of concentration of levels were confusing
12 and perplexing in many cases, if not the majority,
13 to Mr. Cimbura.

14 Q. We will get to those.

15 Let me just explore a bit your
16 knowledge of digoxin. We know it is a complicated
17 drug and we have heard in evidence as well that there
18 may be instances -- although not common -- there
19 may be instances in which the levels of digoxin ante
20 mortem in serum may increase even though the therapeutic
21 administration of the drug ceases under certain
22 clinical conditions, although they seem to be not
23 yet very well understood. And it is thought that
24 there may be some unbinding process that is at work
25 or some elevated potassium level or some renal
function that is impaired, but that there is, and



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2 we have heard, for instance, from Dr. Spielberg, that
3 there are some cases at that time, since the time
4 in question, in which the level of digoxin in
5 a live baby had increased in the serum, even though
6 the therapeutic administration has ceased.

7 Now, my question is, very simply, is
8 that something you were aware of at the time?

9 A. No, I wasn't. I would have
10 thought ordinarily that having ceased digoxin adminis-
11 tration in any given patient that from there on the
12 serum level would fall. At least, we certainly hope
13 that would occur in patients who we think are
14 digitoxic.

15 But, one certainly has to be aware
16 that you are looking at serum levels, and as with
17 other substances, potassium, for instance, serum
18 potassium, we are guided by serum potassium. We are
19 really interested in the cellular and the immediate
20 extracellular level of that ion.

21 Q. Yes.

22 A. And we are guided by a serum
23 level in the same way with digoxin, it doesn't
24 tell you what the concentration is in given tissues.
25 We know that there is a preferential binding but the
serum level is a guide.



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Q. Yes?

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A. But I wouldn't expect it to rise after you stopped giving digoxin. However, if experts say it does, then...

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Q. Well, I don't think ---

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A. It's interesting.

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Q. I don't think it is common, but there are instances that that has occurred.

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A. It can occur, yes.

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Q. The experts have told us and they have given us their best opinion as to why they think that occurs.

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As well, we have heard from the experts that with respect to digoxin and digoxin levels in serum there is enormous variability amongst infants.

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That is, some infants may have very high readings. I think Dr. Spielberg again mentioned a reading being of something like 16, 14 or 16 in an infant who has taken his grandmother's pills of digoxin and was showing very mild signs of toxicity and was discharged from the Hospital for Sick Children with a level of 7 or 8, showing no signs of digoxin toxicity.

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That was, I think, given as an example

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2 of the variability or range that is possible
3 between or amongst infants. Is that something
4 that you were aware of at the time that you did this
5 review, that there is inherent in digoxin the
6 possibility of very wide variables amongst infants;
7 I think much more so than in adults?

8 A. Well, certainly as I have
9 stated already it is known and recognized and has
10 been recognized for a very long time that serum digoxin
11 levels in infants can be in the 3.5, 4.5 range
12 certainly with the child exhibiting digitalis
13 toxicity whereas in the adult that would be
14 certainly, when you are getting up to 4.5, you
15 would be quite likely to be seeing symptoms of
16 digitalis overdosage.

17 So it seems that infants and very
18 young children can tolerate higher concentrations
19 without clinical manifestations of digitalis toxicity.

20 I am intrigued to hear of levels of
21 the sort that you are talking about, 16 nanograms
22 per millilitre.

23 If the child came in with that, you
24 know, and I was given that, I would be very worried
25 about the child.

Q. Yes.



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A. But it is interesting. As a biologist and after all that is what doctors are, specialist biologists, I am well aware of biological variation.

Q. All right. Finally we have heard also in evidence the possibility at low levels at least of a substance that is like digoxin but is not digoxin.

It has been described as Substance X, and was that something that as a phonemonon you were aware of at the time you did this review?

A. No, I wasn't aware of it and I found it very interesting since I heard about it because of some work that we did some 20 odd years ago on cardioglobulins using the method of Hadju from the National Institute of Health in Washington, and we showed and there has been published -- I think it is in my curriculum vitae anyway -- that in the blood of normal infants, newborns, there was a substance which increased the force of contraction of the heart which, of course, is one of the actions of digitalis so in retrospect that interests me. But I wasn't thinking of it at the time that I was reviewing these charts.

Q. Now, Doctor, turning from your



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2 knowledge of digoxin as it existed at the time of
3 your review, let me turn now to what Dr. Rowe had
4 to say about the possibility of an intentional over-
5 dose of digoxin in one or more babies.

6 Dr. Rowe as I recall his evidence
7 said basically this: that if you tell us, if the
8 inquiry tells him or somebody tells him that Baby
9 Cook was given an intentional overdose of digoxin;
10 that is, rather than error, then he is concerned --
11 he was concerned -- Ms. Cerchetto is whispering
12 where is this? It is in Volume 18, Page 3275, and
13 this was at the windup of Mr. Lamek's examination
14 of him, but he was concerned of that possibility
15 with respect in the end -- he added two babies --
16 seven other infants so that we get a total of
17 eight and it is the very eight infants that you are
18 most concerned about.

19 But he propositions all that on
20 being told that Baby Cook was given, intentionally
21 given an overdose of digoxin rather than being given
22 in error.

23 MS. CRONK: Mr. Commissioner, I
24 don't like to interrupt my friend, but I don't
25 think that is entirely fair to Dr. Rowe.

Dr. Rowe's evidence, as you will



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2 recall, Mr. Commissioner, was that he expressed the
3 opinion that in the case of Justin Cook it was,
4 in his opinion an intentional overdose, but he
5 didn't know and he also said that in his opinion
6 unquestionably death in that case was caused by
digoxin intoxication.

7 MR. ROLAND: And I don't dispute
8 that. I am just getting to that.

9 MS. CECCHETTO: Perhaps my friend
10 would read the passage.

11 Q. The question was asked by
12 Mr. Lamck:

13 "Q. Doctor, of all the 36 deaths
14 that we have reviewed together over
15 the past three weeks, I know that you
16 have said that after March, 1981 you
17 had to consider all of those deaths
18 as possibly having been caused by
19 digoxin intoxication. Let me ask you,
20 of the 36, which do you now regard as
most likely to have been caused by
digoxin intoxication?

21 A. Well, I think that Cook
22 unquestionably is one that I think
23 that had happened. I think it is
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2 possible that a number of others
3 that where the evidence, and I use
4 that knowing that I'm not an expert
5 in that area, it seems to me that
6 from the information that I have,
7 at least subject to further discussion
8 and debate by people who are experts
9 in their fields, I would put about
10 six others in that category."

11 And you said about Justin Cook, my
12 friend is quite right, and I was getting to that,
13 that he had to take the toxicological information
14 about Cook into consideration when he gave his
15 best opinion as to the cause of death of Justin
16 Cook and he can't ignore it.

17 There is a high ante mortem level
18 and significant post mortem tissue levels. And he
19 said in his best opinion the cause of death in
20 Justin Cook was digoxin intoxication, and he
21 said -- he thought, uninformed about the matters of
22 whether it could be an error or because he hadn't
23 reviewed the specific facts about the possibility of
24 error, he thought that kind of error was
25 unlikely but he said if you tell him that it
isn't an error, that it was intentionally done,



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administered to Justin Cook, then he is very concerned about, as it turns out, the other seven babies you are concerned about plus he added, sort of apart from that, Velasquez as a baby that we were concerned about an overdose or an idiosyncratic reaction to naloxone rather than digoxin, but if we are just restricting ourselves to digoxin he is concerned about seven other babies.

I take it that is basically what you are telling us, but if you tell us that as the police did and as the Crown attorneys did in your case that there is murder, and the murder weapon appears to be digoxin, there is a murderer and a murder weapon, digoxin, then you are very concerned about these eight babies as being probable or likely candidates for murder.

MR. YOUNG: Just let me be clear. I'm sorry to interrupt you, Mr. Roland, but as we discussed yesterday there was one other individual mentioned that word I'm not supposed to mention and that was Judge Vanek, and I think to be fair that should be put to the witness also.

MR. ROLAND: Yes.

Q. It is based on Judge Vanek's conclusion that there were four murders.



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2 That is the basis upon which you started your
3 review.

4 A. Well, that's right.

5 Q. Yes.

6 A. As I have said several times
7 and the Commissioner must forgive me. I don't like
8 using the word myself but --

9 MR. COMMISSIONER: That's all right.
10 You and I are determined not to use it.

11 THE WITNESS: Thank you.

12 MR. COMMISSIONER: So let other
13 people use it if they want to.

14 MR. ROLAND: Now Dr. Rowe was also
15 asked through his examination and cross-examination
16 in detail about a number of, in reviewing the babies,
17 about a number of things including the non-specificity
18 of the symptoms of digoxin toxicity. And he was
19 asked in great detail about those symptoms, first of
20 all, and he listed those symptoms as being brady-
21 cardia, vomiting, sudden deterioration or onset of
22 terminal events, ventricular fibrillation, arrhythmias
23 and shallow respiration.

24 What he said is that all of those,
25 all of those symptoms are consistent with but not
indicative of digoxin toxicity.



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I take it you agree with that?

A. Absolutely.

Q. And in fact as I heard your evidence yesterday and the day before you are concerned that you might put even less significance on vomiting than perhaps Dr. Rowe does as a consistent symptom of digoxin toxicity.

As I heard your evidence I thought you said that it is not particularly frequent with digoxin toxicity in your view.

A. Well, no --

Q. Am I wrong in that?

A. Well, in adults whom we consider to be in digitalis toxicity where they may be nauseated and anorexic, you don't see them going around throwing up except I would say except in the extremely unusual cases.



J/BM/ak

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2 With babies certainly it is a symptom of digitalis
3 overdosage. How frequently it causes vomiting in
4 babies I'm not certain, babies vomit for all sorts
5 of reasons all the time. So, although I did when I
6 was reviewing the chart did note vomiting, in fact
7 if I look again at where I put vomiting and at the
8 time perhaps base weight on it, the vomiting is
9 distributed fairly evenly between these other
10 categories down here. So, it doesn't only occur in the
cases.

11 Q. And we know that the result of digoxin
12 toxicity at a fatal level is that the heart stops,
13 in children, generally, the heart muscle simply stops
14 contracting, it is bradycardia I gather down to
cessation of the contractions and in some cases
ventricular fibrillation.

15 A. Yes.

16 Q. I have asked you to review
17 Volume 19, beginning at page 3324 of Dr. Rowe's
18 testimony, I think about 150 pages or so, and you
19 were good enough I understand to do that. That is
20 Mr. Scott's cross-examination of Dr. Rowe in which
21 he went through 14 other causes of death where the
22 same non-specific symptoms or a number of them are
23 also evident; that is 14 causes of death other than
digoxin toxicity.



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Doctor, did you have an opportunity to review that evidence?

A. Went right through it.

Q. Yes.

A. And the 14 that were listed by Dr. Rowe with the assistance of Mr. Scott were these, and I will review them just very, very quickly: heart failure, either from an anatomical abnormality or from disease or infection, hypoxia, sepsis, respiratory illness, instability of temperature, which I think in babies they were talking about, as I reviewed that evidence, mostly hypothermia, a low birth weight and then four kinds of conduction failure, ascidosis, apnea, anemia and Di George Syndrome.

Doctor, can you tell me, in your review of that, do you agree with the evidence given by Dr. Rowe that those 14 other causes of death exhibit either all, or in some cases, most, but maybe not all, but most of the same non-specific symptoms of digoxin toxicity that we have discussed this morning?

A. Yes, I do. Mind you, a couple of the things like hypothermia I would like to know what degree of temperature depression we are talking



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about and anemia I would like to know, you know,
what sort of severity of anemia we are talking about.
But, yes, I agree with what Dr. Rowe says in his
evidence.

Q. Now, Doctor, let me turn to
another subject and that is the subject of seizures.
We have heard from Dr. Rowe and his review about the
findings in the charts and clinically that there were
seizures near or shortly before the terminal events
of many of these babies and Dr. Bain reviewed those
and told us that he found 16, I think 16 of the 36
babies that we were primarily concerned with who
apparently had seizures, at least as disclosed by
the charts prior to their terminal events. You have
told us that seizures are not something that is
common or one would expect with digoxin toxicity.
We have a paper in evidence, it is an exhibit, a
paper by Dr. Fowler I think written about 1962, it is
his review I think about 36 babies who died of digoxin
toxicity, he found only one that exhibited a seizure.

A. Is this Dr. Rod Fowler?

Q. This is Dr. Rod Fowler.

A. Yes.

Q. Which was 3 per cent. And I
think a review of the literature showed 6 per cent,



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an indication of seizures associated with digoxin toxicity.

Dr. Bain said that he found that very unusual that there was this number of babies exhibiting seizures or seizure-like activity shortly before or at the time of their terminal events and he said that is something that remains unexplained in these babies.

Do you have any explanation in your chart review, did any explanation occur to you for what appears to be a high incidence of seizures in these babies shortly before their deaths?

A. I didn't take any evidence of seizures as being indicative of digitalis intoxication. I would have thought that most unusual. I'm interested to hear of Dr. Fowler's paper.

Q. Well, it seems to confirm your view that he could only find one in 33 in which there was that phenomena.

A. I would have thought that is extraordinarily rare, yes.

Q. But my question really is, I gather you are as confounded by this phenomena that appears to be exhibited in the charts as Dr. Bain was, that there doesn't seem to be any explanation for this high incidence of seizures that you could see.



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A. Well, certainly from my point of view, looking at it from the possibility of digitalis overdosage being the cause or a major contributory cause, or whatever you want to say, to death in these children, I didn't take seizure activity or seizing as an indication that this was more likely, no.

THE COMMISSIONER: I think the question though is whether you took as an indication that they were not suffering from digitalis toxicity. I think that is what Mr. Roland is getting at.

THE WITNESS: No, I didn't, I don't think I did.

THE COMMISSIONER: Do you now? This may not be what you are asking. Does the fact that the child has a seizure, does that indicate to you that he is not suffering from...

THE WITNESS: No, no.

THE COMMISSIONER: All right.

THE WITNESS: I don't think so.

MR. ROLAND: Q. What I thought, and I may be wrong, but what I thought Dr. Bain was trying to express to us was that there seems to be something else going on that no one has yet explained or can't explain that with this high incidence of



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seizures there may be some phenomena occurring that we don't understand and I had wondered if you had any explanation that might help us?

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A. No, I don't have any explanation.

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I accept what Dr. Bain is saying and I understand perfectly the point that you are making. All I'm saying is that it doesn't sway me in the direction of digitalis toxicity which goes along with what Dr. Fowler has supported in that paper and it doesn't sway me against it because I can't take that into account, I don't know what that means.

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Q. All right. In reviewing the

Miller chart, let's turn to Miller for a moment, I take it from your evidence that you recognize that Miller was a very seriously ill baby and what again persuaded you that digoxin toxicity was a real concern in Miller, it was of course accepted as one of the four, but what persuaded you in the short discussion you had about that baby was the post mortem, the high post mortem digoxin serum readings.

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A. Yes.

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Q. Was there any discussion even in that short discussion about Baby Miller that there may be some explanation for those high readings such as we have heard, the possibility of unbinding of



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digoxin in the heroic efforts made to resuscitate Baby Miller which resulted in a substantial assault on Baby Miller's heart. Was there any discussion about that?

A. I can't remember much discussion about Baby Miller, but I certainly can't remember any discussion about the possibility of resuscitative efforts having raised the digoxin level.

Q. I see, all right.

A. Is that the question?

Q. Yes, that's fine. Was there any discussion about some pathophysiology occurring with respect to Baby Miller that might explain the high digoxin levels, was there any discussion about that?

A. I don't remember any discussion about it, now.

Q. Now, with respect to Baby Estrella, I take it, like the others, you relied for your conclusion with respect to Baby Estrella, of course, it was again one of the four, but you relied for your conclusion that in agreeing that this was likely a murder case, on the 72 reading from the gutter fluid sample.

A. I relied very heavily on that



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I would say, yes.

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Q. All right. I take it though from your chart review you also recognized that Baby Estrella was a very sick baby?

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A. Oh, yes. This baby had severe congenital heart disease.

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Q. I see.

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A. Mind you, it got through the immediate postoperative period and then had the terminal arrhythmia.

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Q. Yes.

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A. Bradyarrhythmia, became asystole but there is no question to my mind that the 72 nanogram per millilitre report was most important in my putting Baby Estrella where I did in categorizing the baby's death. I can't remember when I heard first of the gutter blood problem.

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Q. And I take it, Doctor, that you would put Baby Estrella in the category that she is in even if there was evidence that disclosed that her death was entirely consistent as well with her clinical condition. That wouldn't affect or that doesn't affect your conclusion that you've got to draw and that you did draw from the 72 reading?

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A. No, no. I would have to hold



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to that in the context of what I was doing, my examination, because all of these children almost without exception had serious congenital heart disease.

Q. And your conclusion, based as it is on that 72, isn't affected by, for instance, what we have heard from Dr. Rowe, that Dr. Duncan's view - Dr. Duncan was the doctor, the cardiologist that treated Baby Estrella.

A. Yes.

Q. His view was that this was one of the sickest babies he had seen in a long time and that as far as he was concerned the cause of death was clearly chronic heart failure. That was Dr. Rowe's evidence he gave us about his conversation with Dr. Duncan. We haven't heard from Dr. Duncan himself. But that doesn't affect your exercise because you have that 72 figure for the digoxin.

A. Yes, I respect Dr. Duncan's opinion greatly and clearly the child was very sick indeed, but that was part of my problem, you know. I wasn't asked to look at the management of the child or the anatomic abnormality, as I have stated previously and, so, I have still to stick with the 72 nanograms per millilitre as being the most important



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factor in my categorizing this baby's death and now I am coming up against something where you are taking me out of my area of knowledge into, you know, gutter blood and so forth.

Q. That's right. I gather the legs are knocked right out from under your conclusion if the 72, if you are told the 72 figure is spurious. If you are told that, then you have to move this baby I take it from your highest category to your lowest category.

A. If you tell me that is spurious, again, if you say instead of 72 it is 8, then you put it into a range which sounds within the acceptable or near normal or what have you, then clearly I cannot sit here and tell you I will not budge or change my opinion, that would be ludicrous.

Q. In fact, you would have to - I put it to you, Doctor, if the 72 was something that was removed from the equation entirely, you then would be left with the clinical condition of Baby Estrella and you would have to put it into your natural causes, natural death category, that's all you would have?

A. Well, I would today, but maybe even then I might have put it into suspicious, but



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then again, if you are talking to me and brought that
out today I would remove it and put it down one
category lower, yes, that's the way it would go.

Q. Now, let's turn to Babies
Belanger and Lombardo. Just so that we understand
your evidence, what we have with respect to Babies
Lombardo and Belanger is a situation in which digoxin
was found in exhumed tissues, and there was no digoxin
that had been prescribed for either baby. We have
heard in evidence from Dr. MacLeod, a pharmacologist
at the Hospital for Sick Children, that if that is
digoxin, if indeed that is digoxin, then it must
have been administered, there is no other way that
digoxin could have gotten into those tissues, and I
take it you would agree with that?

A. Yes, I would.



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Q. And the way in which we can best determine whether or not that was indeed digoxin found in the tissues of both those babies is by analyzing the tissue samples by mass spectrometry, would you agree with that?

A. Yes, I would think so.

Q. Let's conclude for the moment, or let us assume for the moment that that is indeed digoxin found in the tissues of both those infants.

The next thing that Dr. MacLeod says about it is that you can't draw any conclusions about the quantity of the digoxin found in the exhumed tissues; I take it you would agree with that?

A. I would think so, yes, certainly.

Q. I think that is basically what Mr. Cimbura says is that you can't rely on, in a quantitative sense you can't rely on those, the numbers that he produces in his analysis.

The next thing that Dr. MacLeod says is that digoxin may be bound for a very long time in tissue, weeks or months; and I take it you would agree with that.

A. In the living human being?

Q. In the living human being, exactly.



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A. Weeks or months?

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Q. Yes.

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A. Digoxin?

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Q. Yes.

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THE COMMISSIONER: I think fairly,

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some of it may.

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MR. ROLAND: I am sorry,

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Mr. Commissioner?

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THE COMMISSIONER: Some of it may.

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MR. ROLAND: Q. Yes, some of it may,

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not all of it, it is excreted but there will remain

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even after many weeks I think he said even a couple

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of months there will remain, or there will likely

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remain some digoxin bound to tissue.

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A. Minute amounts I presume.

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Q. Well, that is the difficulty,

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they don't know how much because it has never been

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tested; but certainly his evidence as I recall it is

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that there will remain some digoxin bound in tissues

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after a long period of time.

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A. And Dr. MacLeod is a clinical
pharmacologist?

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Q. He is a clinical pharmacologist,
yes.

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A. Well, I would have to accept

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2 his expert opinion. I would have thought digoxin
3 would have been cleared within a matter of a week or
4 two fairly completely, but if he says some remains
5 bound I will have to accept it.

6 THE COMMISSIONER: I think you are
7 right, I think that is what he did say, but some will
8 remain.

9 THE WITNESS: If he says so.

10 THE COMMISSIONER: Some will remain -
11 we are talking about in life, are we not.

12 MR. ROLAND: Yes, we are talking
13 about in life, yes.

14 THE COMMISSIONER: In death it will
15 remain much longer.

16 MR. ROLAND: Q. So that with respect
17 to Babies Belanger and Lombardo, isn't it so, Doctor,
18 that all we have, that we can rely on, is a finding
19 of digoxin qualitatively in tissue and we can't from
20 that fact draw any conclusion about when the digoxin
21 was given?

22 A. No, I don't think we can.

23 Q. And because we can't do that,
24 and we can't draw any conclusion about how much was
25 given.

A. That neither, no.



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Q. And because of that we can't conclude that because it was found in the tissues of those two babies that digoxin, an overdose of digoxin was the cause of death of either of those two babies.

A. No. But you have already explained the situation in which I was placed in reviewing the charts.

Q. Yes.

A. And that is a different matter from that standpoint.

Q. Yes, we have done the setting and we can go to those figures, and you have agreed with my analysis I take it?

A. Yes.

Q. Now, let's turn to Baby Hines. We heard from Dr. Becker who was a pathologist at the Hospital for Sick Children who did the autopsy on Baby Hines and who is said to be an expert in SIDS, that in his view there was no doubt that this baby - or there was little doubt that this baby died of SIDS, and he arrived at that conclusion because he found four of the characteristics of SIDS indicators at autopsy. He was asked about the possibility of digoxin being the cause of death of



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2 Baby Hines, because again with Baby Hines digoxin
3 was found in tissue.

4 A. Yes.

5 Q. And Baby Hines had not been
6 prescribed digoxin. He said the problem with that
7 is that digoxin is the cause of death, does not
8 explain to him as a pathologist, does not explain
9 the four indicators he found of SIDS at autopsy.
10 I take it - and as a pathologist he finds those
11 four indicators and needs an explanation, and the
12 explanation is SIDS and digoxin toxicity.

13 THE COMMISSIONER: I'm sorry, but
14 are not those indicators missed-SIDS?

15 MR. ROLAND: Q. Or missed-SIDS, yes.
16 It is for that reason that he arrives at the conclusion
17 that Baby Hines died of SIDS. He goes on to say, I
18 think, fairly, that it is possible, it is quite
19 possible that Baby Hines was given an overdose of
20 digoxin that caused the death of Baby Hines, but he
21 couldn't conclude that from anything that he found
22 in the pathology at autopsy.

23 Now, in light of that I take it you
24 would agree that SIDS is - and in light of Dr. Becker's
25 opinion it's a valid answer to the question of what
caused Baby Hines' death.



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3 A. We are getting a little foggy
4 and misty here. For instance, I don't know anything
5 else that a pathologist could find in order to say
6 this cause of death is dig. toxicity other than the
7 toxicology. I don't know anything else that he can
8 see anatomically. You may produce something that is
9 seen electromicroscopically which would be newer
10 information to me, but I don't know anything that he
11 can say.

12 THE COMMISSIONER: I think we under-
13 stand that. I think the question though is do you
14 accept SIDS as a cause, as a conceivable, valid,
15 likely and probable, and any other kind of cause of
16 death?

17 THE WITNESS: Yes, I can accept it
18 as a possible explanation for this child's death,
19 Mr. Commissioner. The child had had a missed-SIDS
20 episode where the baby had become limp I presume and
21 nearly died before the eventual fatal outcome. As
22 an experienced pathologist who has studied this
23 of course he is clearly very well qualified to
24 comment on his post mortem findings.

25 I don't know, you know, how much the
pathologists want in order to feel very confident
indeed on the diagnosis, because a lot of the things



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2 that are found in SIDS babies are also found in a
3 proportion of normal babies dying of other causes.
4 So I suppose what he is saying, as I understand it
5 is that he found a lot of these changes, and there-
6 fore putting them altogether with sudden death he
7 says that is a good enough explanation, and that may
8 have been the explanation; but again no digoxin had
9 been ordered for this baby and digoxin was found
10 post mortem.

11 MR. ROLAND: Q. And it was found
12 like the infants Belanger and Lombardo, as I under-
13 stand it it was found in the exhumed tissue?

14 A. Yes.

15 Q. So one says the same thing
16 about Baby Hines as we have already discussed about
17 Babies Belanger and Lombardo.

18 MS. CRONK: Well, here again to be
19 fair to the witness, Hines is in a different category
20 with respect to toxicology than the other two, they
21 are fixed and exhumed tissue specimens where digoxin
22 resulted.

23 MR. ROLAND: Well if there is
24 fixed tissue I think what Mr. Cimbura says about that
25 is that he certainly can't be as confident about
fixed tissue as he can about fresh, but he can be



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more confident about fixed tissue than he can exhumed.

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Q. Well, in any event, again I take it whether or not that was actually digoxin is something that could be answered by a mass spectrometry but we don't have any mass spectrograms results for many of those samples.

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A. Yes.

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Q. Now you have said, Doctor, just in response to the last question or so, that it is extremely difficult for a pathologist to find digoxin, or digoxin toxicity as a cause of death because - without some toxicology information.

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A. I presume this is what the pathologist would base his evidence on. I don't know what else he would base his evidence on unless you can give me some very latest research on the subject, perhaps I am out of date.

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THE COMMISSIONER: No, I think we are about as recent as anybody, there doesn't seem to be any.

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MR. ROLAND: Q. Doctor, I gather as a clinician you in a sense have the same sort of problem as I think Dr. Rowe expressed, in excluding digoxin toxicity as a possibility in almost any death. That is that the symptoms of digoxin toxicity are



1
2 so non-specific that the dilemma I think Dr. Rowe
3 expressed after he testified for some six weeks was
4 that in almost every case there is a possibility of
5 an overdose of digoxin as a cause of death because
6 the symptoms of digoxin toxicity are so general. I
7 take it you basically agree with that from a clinician's
8 standpoint?

9 A. Well, if the patient is on
10 digitalis and develops an arrhythmia, be it an
11 excitant arrhythmia, or a depressant arrhythmia;
12 be it a tachycardia, or a super ventricular tachycardia;
13 or brady arrhythmia heart block; ventricular standstill;
14 ventricular fibrillation, and is on digitalis then
15 I suppose that is right. If one is dealing with a
16 patient with heart disease all these arrhythmias can
17 develop too. But if you come right down to the
18 bottom line I have to give you one answer, yes,
19 it is possible that it may be due to digitalis.

20 You know, we are so - I am so used
21 to seeing arrhythmias out of this setting too, that
22 I see them all the time on patients who don't have
23 digitalis and it is not very often in practice that
24 one is looking at these arrhythmias in digitalis
25 toxic patients whom one is now recognizing that this
is where we are in trouble here. We know there is



1
2 a high assumed digoxin level and here we are with
3 these arrhythmias and that is a very serious matter;
4 but we're not often in that situation, we are very
5 often in the situation of dealing with lethal or
6 potentially lethal arrhythmias certainly in my adult
7 patients I am all the time.

8 Q. Doctor, one last matter and
9 it arose this morning and it is has to do with
10 Baby Inwood. There was some discussion about what
11 the concentration of Lasix is.

12 A. Yes.

13 Q. Or epinephrine, what the
14 concentration is and we had a large vial shown to you
15 which showed a concentration of ---

16 A. 10 milligrams per millilitre.

17 Q. And we have been able to deter-
18 mine since that time that it only comes in that
19 concentration, although it comes in two sized vials,
20 2 millilitre and 4 millilitre, it only comes in the
21 concentration 10 milligrams per millilitre.

22 THE COMMISSIONER: We are talking
23 about Lasix now, are we?

24 MR. ROLAND: Yes.

25 MS. CRONK: Sir, I am trying not to
quarrel with my friend this morning, but can he help



1
2 us with this - is the information provided to him
3 in the context of what was available then on the
4 ward, or are we talking today, because the same
5 problem has arisen with all the vials and the answers
6 to questions. It is obvious by the question now put
7 to the witness that we should know what we are talking
8 about.

9 MR. ROLAND: I don't know that we got
10 that answer clearly and it may be -

11 THE COMMISSIONER: I wouldn't be
12 surprised if this is evidence that you can give
13 though that you don't have to ---

14 MR. ROLAND: No, I did my best,
15 I had Miss Thompson do her best over the break to
16 try and answer the question that you were raising
17 this morning.

18 THE COMMISSIONER: Yes.

19 MR. ROLAND: And the answer we got
20 back, and if it was different then than it is now
21 we will let you know.

22 THE COMMISSIONER: Yes, all right.
23 Tell me what is the answer?

24 MR. ROLAND: The information we
25 have freshly this morning is that the concentration
is 10 milligrams per millilitre.



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Q. So that in Baby Inwood I think the prescribed dosage of Lasix was 3 milligrams, that would mean .3 millilitres by volume. As I understand one pediatric vial of digoxin is 1 millilitre.

A. Yes.

Q. So we are talking about if digoxin was substituted in error for Lasix then we are talking about a third of a pediatric vial, about.

A. About 15 micrograms, yes, probably.

Q. Or by volume it is a third of a pediatric vial and you say about 15 micrograms by weight.

A. 15 micrograms.

Q. 15 micrograms.

A. It contains 50 micrograms per millilitre which is all the vial contains.

Q. Yes, right. I take it that is a relatively small dosage of digoxin?

A. It is not a great big dose of digoxin by any means, 15 micrograms.

Q. It isn't something I take it in your view if that was digoxin error that would likely constitute an overdose for Baby Inwood that would result in her demise?



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A. Well, I don't really think so,
no.

MR. ROLAND: Thank you, those are
all my questions.



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THE COMMISSIONER: Miss Chown?

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MS. CHOWN: Yes, very briefly,

4

Mr. Commissioner.

5

CROSS-EXAMINATION BY MISS CHOWN:

6

Q. Thank you. Dr. Fay, my name

7

is Chown and I appear on behalf of some of the
doctors at the Hospital this morning.

8

A. Thank you.

9

Q. I want to follow up very

10

briefly on one aspect of something that Mr. Roland

11

dealt with. He outlined quite thoroughly the

12

setting under which you were operating in performing

13

your review, and he indicated the factors that

14

were present in that setting.

15

I believe at the early part of

16

your evidence in this Commission you indicated also

17

that you were operating from the benefit of

18

hindsight in carrying out this review. Is that
right?

19

A. Yes. Yes, it was. Retro-

20

spectroscope.

21

Q. A retrospectoscope and

22

that would be a helpful instrument as we have

23

learned in this Inquiry?

24

A. We find it so in medicine.

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Q. I really want to just follow down that line, that is dealing with hindsight with you, and that is you have also indicated to us that your particular difficulties in carrying out this study were that you were not looking at the management of the case; you were not considering the anatomical abnormalities in each case. You were specifically looking with the narrow focus you had been given?

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A. Well, I would never have accepted an assignment - I don't think I would have been offered one - to comment on the management, diagnosis and management of babies with congenital heart disease by one of the tip-top teams in the world.

15

16

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18

19

Q. I presume it is not belabouring the point to say that you are making that remark simply because you feel that there would be very little that could be called into question about the management?

20

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A. I would never have dreamt of going into that - except as a specific case that had gone to the Coroner where the Coroner wanted an opinion about this one baby but not a series of babies on the Cardiac Ward of the Sick Children's



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Hospital.

Q. Well, Doctor, I am simply going to ask you: we have today been looking at the situations in which if you are provided with further bits of information on particular cases you have been prepared to recategorize that baby within the individual categories you used in your study.

A. Well, I have to. I can't sit with a rigid mind when presented with fresh evidence.

Q. Fairly so. Doctor, I am simply going to ask you to move in the other direction. If we were to strip away the setting in which you performed this task and strip away the toxicological information that you were provided with and strip away your retrospectoscope or your use of hindsight in this matter and really put you in the situation in which you have just said would be very unlikely but that situation being that you were asked by Dr. Rowe or Dr. Freedom or any of the other cardiologists involved with these children to come in at the time of the child's death and to review the case.

Now would it be fair to say, first



1
2 of all, in general terms that perceiving the cases
3 on an individual basis would or might have altered
4 your view of the situation?

5 A. You have taken all this
6 scenario away in which I am introduced to this?
7 You are taking away the toxicology? You are
8 introducing me into the scene as Doctor Freedom -
9 or Dr. Rose or whoever was looking after the baby?

10 Q. Exactly. Doctor, perhaps
11 to be of some assistance if we could take a
12 specific example and that being the case of David
13 Taylor. The note that you made concerning David
14 Taylor is set out at page 9 of your case summary.

15 And, Doctor, I am simply asking
16 you today if after the death of David Taylor which
17 was in July of 1980 you had been called in by
18 the Hospital to look over this case and you had
19 indicated in your earlier testimony that you were
20 influenced by Dr. Izukawa's note?

21 A. Yes.

22 Q. And your reference at the
23 top of the page indicated you looked at the autopsy
24 report of David Taylor.

25 A. Yes.

Q. In the setting in which you



1
2 conducted the review, Dr. Fay, you have indicated
3 that initially you put David Taylor in the possible
4 or suspicious category.

5 A. Yes.

6 Q. What I am simply asking you
7 to do today if you can indeed strip away those
8 factors is to place yourself in the position of
9 being called in in July of 1980 perhaps by Dr.
10 Ted Izukawa and asked if you could review this case
and assist him as to his puzzlement about it.

11 And, Doctor, my question is simply:
12 if you had reviewed the chart in that context and
13 reviewed the final autopsy report would you have
14 at that time with those bits of information
15 entertained a suspicion that digoxin was involved
in this child's case?

16 A. At that time only if Dr.
17 Izukawa had said I am suspicious that there may have
18 been an error in drug administration which is what
19 in fact I was looking at.

20 If he had said that to me then I
21 might very well have said it is possible that the
22 child had too much digitalis. It is possible.
But that is about the size of it.

23 I don't know whether I am answering
24
25



1
2 your question adequately, but that is the best I
3 can do. If he called me in at that time and said
4 to me, you know, will you look at this, and I
5 think there may have been an error in drug
6 administration here, what do you think, I might
7 well have said, as indeed he did raise the question
8 and raised in his own mind, I might well have said
9 well, do you think this baby was given something
10 or do you think this baby because of this brady
11 arrhythmia and you are worried about drug administration,
12 do you think this baby had too much digitalis?
13 Does that make sense.

14 A. Yes, it does, thank you,
15 Doctor.

16 And similarly, in the case of
17 Real Gosselin you have also placed in the category
18 of possible or suspicious, and in your evidence
19 indicated you were struck by Dr. Freedom's letter
20 to the referring physician in which he expressed
21 puzzlement, and, Doctor, it has been put to you
22 that Dr. Freedom in his evidence here explained
23 his comments there.

24 Again if you had been called in at
25 the time of Real Gosselin's death and discussed the
matter with Dr. Freedom at that time, is it likely

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that you would have categorized the death as one that was possible or suspicious of being involved with digoxin?

A. Would I have done that if Bob Freedom had told me that?

Q. Yes.

A. No. But, you know, that is a different flavour from the other situation, you know.

Q. Yes.

A. It is a little bit different. To me as a physician there is a little difference in those two influencing me, those two notes. If Bob Freedom said I didn't refer to that at all, I found out later that this - of course.

Q. I appreciate they are different situations, Doctor, and I take it although it is belabouring a point that when you in your own clinical practice or serving as a consultant to other doctors, that murder or intentional administration of drugs is not a part of an ordinary differential diagnosis of a doctor?

A. Oh, good heavens, no.

MS. CHOWN: Thank you, Doctor, those are all my questions.



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1
2 THE COMMISSIONER: Thank you.

3 Miss Kitley?

4 CROSS EXAMINATION BY MS. KITELY:

5 Q. I shall be brief, sir.

6 I would like to read to you from the transcript
7 of November 23rd, yesterday, which is Volume 68,
8 starting at the bottom of page 4881. And, Doctor,
9 I am going to read what amounts to a paragraph of
10 the evidence you gave yesterday, and what I am
11 asking for is a clarification.

12 The answer that you gave is in
13 connection with the Onofre child and you were
14 saying as follows:

15 "You see I am not looking at this
16 child to see whether the cardiac
17 group at the Sick Children's
18 Hospital are ordering normally
19 accepted doses of digitalis - I know
20 they do that. It is interesting
21 mind you that over the last 20 years,
22 overall, the dosage for infants in
23 the last 25 years has tended to come
24 down. I think it is true that 20
25 to 25 years ago larger doses were
given but of course at that time we



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"didn't have the ability to measure the serum digoxin concentrations. I am not looking at it from that point of view. I do have to look at the dosage - I am not expecting to find an error in dosage, as can occur; of course they occur, but I am not expecting to find that, and I didn't find it. So really in forming my opinion, in giving the opinion I have been asked to give, I cannot really weight the orders for digoxin in my assessment; I really cannot weight the orders. I expected to find them and I did find them in the normal range as ordered."

Am I correct that what you were referring to was that in looking at the charts you did not see an excess ordered?

A. No. No, I didn't see an excess.

Q. In any child?

A. No.

Q. But that doesn't mean that the child didn't receive an excess of digoxin or



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quite frankly any drug?

3

A. Well, that's right.

4

Q. But errors do occur?

5

A. Errors do occur, yes.

6

Q. And if for no other reason

than human failings?

7

A. Yes.

8

Q. And in fact you raised the

9

possibility of Inwood and Miller and the Lasix

10

problem as being error problems.

11

A. Yes.

12

Q. Am I correct, Doctor?

13

A. Yes, they could be.

14

Q. And would you agree with me

in an institution such as a hospital that if an

15

error arises from human failings that the failings

16

can be from an assortment of sources; from pharmacy

17

on the one hand, nursing staff on the other, medical

18

staff on the other? Would you agree with that,

19

Doctor?

20

A. A big hospital like the Sick

21

Children's and like the hospital I work in is

22

a very complex organization, and pharmacy, house

23

staff, attending staff, nursing staff --

24

Q. They all share in part?

25



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A. Yes.

3

MS. KITELY: Thank you, Doctor.

4

THE COMMISSIONER: Mr. Knazan?

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CROSS-EXAMINATION BY MR. KNAZAN:

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Q. Doctor, I represent MaryAnne
Christie who is a registered nursing assistant on
the Ward at the time of the deaths.

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I have only one point to make or
not make. I know you have been bombarded with
different classification schemes: your own, Dr.
Hastreiter's, reduced to two; another one added
yesterday, but I am going to put another scheme
that was used in an epidemiological study which we
will be coming to later and I am going to ask you
from a medical point of view whether you think that
the classifications used were worthwhile?

16

A. That we used?

17

18

Q. No, classifications I will be
putting to you.

19

A. In this epidemiological study?

20

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Q. Yes. Now I just want to begin,
though, by referring you to one or two of your own
cases, and for instance, in Lombardo which is on
page 59 to 61. Looking at page 59 - do you have
that?



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A. Yes, I have.

3

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Q. I understand very well the
context and the task that you were given?

5

A. Yes.

6

7

Q. And that you were limited to
the charts and perhaps the other information in
the police envelope.

8

A. Yes.

9

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Q. But given those limitations
is it correct that you still considered both the
mode of death and whether death was consistent
and expected or unexpected with reference to the
child's clinical status when you came to a conclusion?
That is both those elements?

14

A. I'm sorry? Did I consider?

15

Q. Both the mode of death --

16

A. Yes.

17

18

Q. Whether that was consistent
with some concern about digoxin?

19

A. Yes, I did, yes.

20

21

Q. And whether the child's death
was unexpected or expected in reference to its
clinical status at the time?

22

A. Yes, I did.

23

Q. You considered both of those

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factors?

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A. Yes.

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Q. And when you had the toxicology
you considered that as well; in Lombardo I believe
you didn't at the time?

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A. Yes. I don't know when I
got the toxicology but I certainly took that as
I did in all other cases as I have said into
account and gave it weight.

10

11

12

Q. So you would agree with me
that both of those factors would be important in
coming to your classification in these children?

13

14

15

16

A. Yes.
Q. Now in the study of The
Centre for Disease Control which has not yet been
made an exhibit the consultant cardiologist was
Dr. Alexander Nadas.

17

18

A. Oh, yes. Boston Children's
Hospital.

19

20

21

Q. Was asked to look at the
charts, as we understand it from the report in
a similar way that you were?

22

23

24

25

A. Yes.

Q. And asked a series of questions



1
2 including the question timing of death, and he
3 was given certain options, expected and consistent
4 with clinical status; unexpected but consistent
5 with clinical status or unexpected and inconsistent
6 with clinical status. And features of terminal
7 events relative to possible digoxin intoxication:
8 inconsistent, consistent, consistent with special
9 concern, and he looked at the charts and he gave
10 his opinion with reference to those two questions
and three others as well.

11 Then for the purposes of the authors
12 of the report the children were placed into
13 categories: Category A, B and C, and Category A
14 was described as follows: death with any one of
15 the following criteria. The timing of death scored
16 unexpected and inconsistent with clinical status
17 by the consultant cardiologist or mode of death
18 scored consistent with special concern regarding
19 possible digoxin intoxication by the consultant
cardiologist?

20 A. Yes.

21 Q. Or, and then it refers to the
22 score that the consulting pharmacologist put on the
digoxin, on the toxicology information.

23 A. Yes.

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Q. Now, my question is, can you see any validity in separating the two factors which the consultant cardiologist was asked to look for and making a category which included one or the other?

THE COMMISSIONER: I don't know that the witness understands that.

THE WITNESS: It's obvious. Dr. Nadas had been given this form by a statistician from the Centre for Disease Control. Now, I wasn't given that form and I haven't had a look at that form and I didn't approach it that way. He clearly was being given guidelines by a high powered group of statistically oriented people and I don't know what to reply to that question, I really don't.

THE COMMISSIONER: Well, I was just thinking, this is a question surely for the epidemiologists who are going to be called. I don't know, perhaps --

THE WITNESS: I would like to try.

THE COMMISSIONER: All right, you try.

MR. KNAZAN: Q. I don't think I crystalized the question very well, but it is certainly a question for cross-examination of the epidemiologists.

A. Yes, I'm not trying to evade



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it.

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Q. It seems to be, in Lombardo,

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and I can put other examples to you, this is a

5

difficult job, you have to balance everything you have

6

and you considered both modes of death?

7

A. Yes.

8

Q. And clinical status of the

child?

9

A. Yes.

10

Q. And you could probably go

11

through your notes and make an and/or list as well.

12

A. Yes, I could.

13

Q. And if you did, your first

14

category of seven or, if you want to include Hines,
eight, it might be indeed longer?

15

A. Yes, it might.

16

Q. For instance, David Taylor,

17

if you were doing and/or, that is at Page 8, Doctor.

18

A. Yes, yes.

19

Q. It is in Suspicious.

20

A. Yes.

21

Q. And in your group 3?

22

A. Yes.

23

Q. But if you had been asked

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to make a Group A, which had either mode of death

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giving rise to concern or death inconsistent or unexpected with respect to clinical status, then Taylor might be moved into a higher category.

A. The two categories again are?

Q. Yes, timing of death scored unexpected and inconsistent with clinical status or mode of death scored consistent with special concern regarding possible digoxin intoxication.

A. Well, I clearly categorized it in the latter category, didn't i?

Q. Yes.

A. And you are saying?

Q. That if you had been told to put a child that has either one of these into your highest category, then your categorization would be very different?

A. I suppose you are right.

Q. But from a consultant pediatric cardiologist's point of view the best opinion is one that comes from a combination of both mode of death and clinical status.

A. Yes, I suppose, yes, yes.

Q. Thank you.

A. Thank you.

MR. COMMISSIONER: Mr. Olah?



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MR. ROLAND: While Mr. Olah is getting set up, Ms. Cronk jumped to her feet concerned about what the concentration of lasix was in 81 and we have now got an answer for her.

THE COMMISSIONER: Yes.

MR. ROLAND: It is exactly the same concentration as it is today.

MS. CRONK: I am grateful, sir, and impressed.

THE COMMISSIONER: Say what you like about Mr. Roland, he is certainly speedy with the answers.

MR. OLAH: Ms. Thomson's running shoes must be wearing out.

MR. ROLAND: I would like to hear what else she says, you are suggesting there are other things.

CROSS-EXAMINATION BY MR. OLAH:

Q. Doctor, I, as the previous examiner, act for one of the registered nursing assistants by the name of Janet Brownless on the Trayner team.

A. Thank you.

Q. I was interested to follow up something you said and I think which is the under-



1
2 pinning of your evidence to some degree, you
3 talked about the retroscope.

4 A. Yes.

5 Q. And I have always thought
6 about it as wearing a pair of glasses and looking at
7 a set of facts through a certain tinted pair of
8 glasses. Isn't that what you were doing, wasn't
9 that your brief or your retainer when you were in-
10 structed to review all these charts?

11 A. It is to a certain extent,
12 yes, I agree with you and it is to a certain extent
13 true when I review any chart, death chart in my
14 hospital.

15 Q. All right.

16 A. You know I am in a different
17 position.

18 Q. I know the difficulty you are
19 in, Doctor, but let's see if we can explore it
20 together, the ramifications of that perspective or
21 that retroscope with those pair of glasses. What
22 you were wearing, those glasses that you were wearing
23 were really a pair of glasses that made you lean towards
24 suspicion of digoxin, isn't that it?

25 A. Made me lean towards...?

Q. Towards a suspicion of digoxin.



1
2 If you looked at a set of facts which could have
3 been digoxin related or natural, your vantage point
4 or your brief, as you were instructed, was to look at
5 it from the digoxin perspective?

6 A. I'm pleased to hear you say
7 that because that's what I've been saying these last
8 three days.

9 Q. All right. And that's what
10 I thought you were saying and I just wanted to
11 articulate it clearly. So that it was a digoxin
12 set of glasses or perspective that you approached
13 this case from.

14 A. Yes, yes, all right, if you
15 want to keep on with glasses, yes.

16 Q. All right. Well, Doctor,
17 I guess if I asked you to put on a different set of
18 glasses and look at this situation from a different
19 mode --

20 Q. Yes.

21 Q. That may radically alter the
22 conclusions you arrived at or may.

23 A. It might, yes.

24 Q. All right. Well, let's try
25 those spectacles, Doctor, you and I, all right?

A. Yes.



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Q. Let's put on the spectacle

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that says that there is an innocent explanation to the
whole situation, all right?

4

5

A. Yes, yes.

6

7

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Q. Because you and I, Doctor,
know that very often when one looks at a situation
with a given perspective it may ultimately lead to
a conclusion that may be unjustifiably erroneous.

9

A. Yes.

10

11

12

Q. So, let's use that different
spectacle and let's see if we can go through the cases
together, all right?

13

A. Yes.

14

Q. Let's start initially with the
death of Stephanie Lombardo.

15

A. Yes.

16

17

18

Q. Lombardo, what you had,
Doctor, is, you had a very sick child, as I under-
stand it.

19

A. Yes.

20

21

22

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Q. And perhaps we can go to the
minutes of the meeting and start there and also go
to your notes which start at Page 59. I don't want
to belabor points that have already been made by
examiners to this point.



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A. Yes.

3

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Q. But Stephanie Lombardo was
a very sick child.

5

A. Yes, she was, yes.

6

7

Q. And as Mr. Roland has already
pointed out, Doctor, you really can't lay digoxin A
to causing the death, correct?

8

A. I can't link it?

9

10

11

Q. In fact, you cannot say with
any degree of certitude that digoxin caused that
death.

12

A. No, no, no, that's all right.

13

14

Q. And so using that spectacle
that we talked about, that death can be just as
likely innocent as intentional administration.

15

A. Could be, yes.

16

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Q. And in fact using that new
set of frames would you not agree with me, Doctor,
that the probabilities are somewhere equal, it can
be innocent or it can be intentional.

20

THE COMMISSIONER: I'm sorry,
intentional?

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MR. OLAH: Intentional administration
or natural cause.

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24

25

THE COMMISSIONER: Yes, but do you mean



Fay, cr. ex.
(Olah)

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2 innocent administration, is that what you are talking
3 about?

4 MR. OLAH: That's correct.

5 THE COMMISSIONER: I didn't think you
6 were talking about that, I thought you were saying
7 it was a natural death versus death by digoxin
8 intoxication, I thought those were the problems you
9 were putting to him.

10 MR. OLAH: Well, the two possible
11 explanations are, Mr. Commissioner, is that you've got
12 somewhere along the way an administration of digoxin
13 which results in digoxin levels in the tissue and
14 the natural cause of death or you've got an innocent
15 administration of digoxin leading to the death or you've
16 got an intentional administration leading to death.
17 Those are the three possibilities.

18 THE COMMISSIONER: Yes.

19 MR. OLAH: The possibility that I'm
20 putting to the doctor at this time is an accidental
21 dose of digoxin given some time prior to death
22 leading to, or having no relation but an innocent
23 or a natural cause of death. That is perfectly
24 possible in this case, is it not, Doctor?

25 A. Well, yes. The only
conclusion one can draw from the digoxin -- I am



1
2 trying to wear the spectacles you provided -- is that
3 the child had digoxin and the digoxin wasn't ordered.
4 So, either it has been given by mistake, and that
5 accounts for its presence being found. Am I going
6 along with you?

7 Q. You are doing just fine, Doctor.

8 A. Thanks. Or it is being given
9 by some mischievous person, but you know that wouldn't
10 ordinarily occur. If you are taking me with these
11 spectacles the place I think you are taking me, not
12 that I'm quite sure of that yet.

13 Q. Let's not worry about that,
14 Doctor.

15 A. If you are taking me out in
16 isolation and you are giving me one case.

17 Q. That's correct.

18 A. Well, we have to agree that
19 the child wasn't supposed to have digoxin and we take
20 it that our toxicologist is correct and he is telling
21 us that there is digoxin there, so, I don't know
22 whether that digoxin was responsible for the child's
23 death or not.

24 Q. That's the very point I am
25 making. So that if you are wearing the spectacles
we are wearing together, wouldn't you agree with me,



1
2 Doctor, that the likelihood of natural death with
3 some sort of an accidental administration somewhere
4 along the way is equally as consistent as intentional
5 administration?

6 A. Oh, if that came up as an
7 isolated case, you present that to me, of course,
8 because we don't go around hospitals thinking of
9 murder. I'm sorry to use that word, Mr. Commissioner,
it slipped out.

10 Q. We are going to have to get
11 the soap out, Doctor.

12 But would you agree with me that
13 wearing that spectacle that the probability or the
14 possibility is at least as equal?

15 A. Yes, yes, I suppose so.

16 Q. All right. And similarly when
17 you go to the Belanger child, that very same explana-
tion and possibility is equally open?

18 A. Yes.

19 Q. Now, let's move on to the
20 death of Janice Estrella. Am I understanding
21 correctly, Doctor, that the problems with taking
22 a gutter sample from Janice Estrella was not discussed
at the meeting of September 13th, 1982?

23 A. Which page is that?
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Q. Well, if you turn to Estrella, you will find that lumped in at Page 220.

A. Yes. Oh, yes, yes, that's right. I don't think it came up, no.

Q. Well, would you agree with me, Doctor, that in retrospect now wearing those spectacles we are talking about that the fact that that was a gutter sample taken some three hours after the autopsy was commenced is something that causes you concern?

A. It would again, considering this case in isolation.

Q. All right. So, wearing those spectacles I have provided to you, Estrella may well, as Mr. Roland indicated, have been a natural death.

A. Might have been; certainly digoxin had not been ordered and digoxin was found, isn't that so?

Q. Well, no, Doctor.

A. Oh, I beg your pardon.

Q. Digoxin was held on or about, I believe, January 7th, because of a fairly high reading, I think it was in the range of about 9.7.

A. Which page are we looking at? I am getting a little bit confused here. Which page



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2

are we looking at of my notes?

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Q. In your book Estrella is to

4

be found at Page 67.

5

A. Oh, thanks, yes, sorry about

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that. Okay, yes, I'm with you.

7

Q. My understanding, Doctor, is

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that there was a reading, a full reading of greater

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than 9.4 on or about January 7th, 1981, several days

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A. Yes.

11

Q. And that's when digoxin was

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discontinued.

13

A. Was held, quite correctly,

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yes.

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Q. Now, if we are assuming that

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that 72 nanogram reading from the gutter sample is

17

either contaminated or there is some doubt about

18

its veracity and all we've got is a vein sample of

19

A. Yes.

20

Q. Would you not agree with me,

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Doctor, that that reading, the second reading of

22

greater than 4.7 is not inconsistent with the reading

23

that had been obtained several days previously of

24

A. Yes, it would seem reasonable

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but it has come down to that in the interim, is

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that what you are saying?

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Q. That's right.

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A. Yes.

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Q. Would you not agree with me
that taking out that 72 nanogram reading that the
clinical status of the child is perfectly explicable
as the cause of death in that case?

9

A. Yes, I think so, yes.

10

Q. All right.

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THE COMMISSIONER: Just before we
get too agreeable now, Doctor. The January 9th
reading was 4.7, not greater than 4.7.

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THE WITNESS: January 9th.

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MR. OLAH: I'm referring to January
7th, Mr. Commissioner.

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THE COMMISSIONER: Yes, I know, but
it turns out to be 9.4 and then it went to 7.8 and
then on January 9th to 4.7.

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MR. OLAH: I think it was actually
5.0.

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THE COMMISSIONER: Which was, on
January 9th?

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MR. OLAH: On January 9th.

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THE COMMISSIONER: Well, then, perhaps

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you are right. But whatever it was, it was not
greater than something, isn't that right?

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MR. OLAH: I'm sorry, I was referring
to the 7th. The Commissioner is right.

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THE COMMISSIONER: Oh, no, you are
quite right, it was greater than 5.0 on January 7th
but there were readings on the 8th and the 9th when
it was going down and I think you have to put to him
and ask him whether that is consistent with the
greater than 5, yes.

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MR. OLAH: You are absolutely right,
Mr. Commissioner and I should have done that,
Doctor.

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Q. Doctor, the other readings
were, on January the 8th, greater than 4.7, actual
reading of 7.8?

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A. Yes.

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Q. And on the 9th it was 4.7
with a natural reading I believe of 5.0?

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A. The toxic range, yes.

11

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MR. ROLAND: I think you are wrong
in that, it was an actual reading of 4.7, that
was the understanding.

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MR. OLAH: That is still high.

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THE COMMISSIONER: Anyway, the
question was, is the post mortem reading on the
vein of greater than 4.7 consistent with the
readings, the other readings, is that what you are
saying?

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Q. Well, the question is precisely
as the Commissioner frames it. If we exclude the
72 reading because of some possible problems with
it and you are left with a vein reading of greater
than 4.7, and you had the reading on or about January
9th, 1981 of 4.7, do you still - wearing those



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spectacles I have provided to you, are you still
in a situation to conclude that the Estrella death
may well have been from natural causes bearing
in mind its clinical symptoms?

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A. Now, let us be clear, you
are removing me from where I am with this chart
when I review it and taking it in isolation again?

7

8

Q. In isolation, wearing your
new spectacles, Doctor.

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A. I would like to get rid of
these spectacles but anyway I am wearing them. Okay,
and you are taking away from me the 72 nanograms
which admittedly I have to ask the toxicologist
about, okay?

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Q. Precisely.

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A. And you are telling me that
two days before the baby died the serum digoxin
level was 4.7 nanograms per millilitre?

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Q. And had been at one point
greater than 9.4?

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A. Which is very high really,
but I would; what question are you asking me, could
digitalis have been responsible for this death?

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Q. No, wearing those new spectacles,
Doctor?

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A. I am finding them very
irritating as a matter of fact.

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MS. CECCHETTO: Perhaps Mr. Olah
should indicate that greater than 4.7 is the
highest level that could be tested.

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THE COMMISSIONER: Yes, yes, well,
it was greater than 4.7. I think the Doctor
understands that. Would you get your question now
Mr. Olah.

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MR. OLAH: Well I am trying to get
to the answer Mr. Commissioner.

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Q. And Doctor, wearing those
new spectacles?

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A. Yes.

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Q. Would you agree with me that
the possibility of natural causes being the
causation of death are equally consistent as
digoxin?

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A. I will go along with equal,
yes, I go along with equal. But you know, yes,
I will go along with equal. There is still that
there is still the possibility because the child was
toxic and I think it is low now the way we are
looking at this, low.



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MR. OLAH: Well I notice it is
1 o'clock Mr. Commissioner.

THE COMMISSIONER: I want to know how
much trouble we are in, how much longer will you
be?

MR. OLAH: I said yesterday I think
20 minutes at the outside, I have been about 14
and I will probably be some time yet, sir.

THE COMMISSIONER: What does that
mean, 6 minutes?

MR. OLAH: I will probably be more
like about 16.

THE COMMISSIONER: Well, we are in
trouble, that's all I want to say. I want to find
out now about Mr. Labow how long are you going to
be?

MR. LABOW: I still expect to be
at least half an hour Mr. Commissioner.

THE COMMISSIONER: Mr. Shanahan?

MR. SHANAHAN: I think I will be
about 15 minutes, sir.

THE COMMISSIONER: I'm sorry, I don't
know your name.

MR. KRANEC: Mr. Commissioner,
I discussed this with Mr. Tobias and Ms. Cronk will



1
2 be conducting the examination and she will not take
3 more than 20 minutes or half an hour, that is
4 because she is more familiar with this.

5 THE COMMISSIONER: I see, I will
6 add these things up. You say you will be how long
7 Mr. Olah?

8 MR. OLAH: I will be about 15
9 minutes, sir.

10 THE COMMISSIONER: And Mr. Labow you
11 said half an hour?

12 MR. LABOW: Yes, Mr. Commissioner,
13 half an hour.

14 THE COMMISSIONER: Mr. Shanahan?

15 MR. SHANAHAN: I think I will be
16 about 15 minutes, sir.

17 THE COMMISSIONER: And Ms. Cronk,
18 although wait a minute, Miss Cecchetto you come
19 in on this too.

20 MR. KRANEC: About 20 minutes.

21 THE COMMISSIONER: You will be about
22 20 minutes, your questions, right.

23 MS. CECCHETTO: If I ask any I will
24 be about 5 minutes.

25 THE COMMISSIONER: Now Miss Cronk,
how long?



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MS. CRONK: Well Mr. Commissioner quite apart from any questions that I put on behalf of Mr. Tobias I obviously have some of my own and I will do everything I can to accommodate your timing.

THE COMMISSIONER: What does that mean.

MS. CRONK: That means if I am left with 10 minutes I will try to be finished in 10 minutes, sir.

THE COMMISSIONER: We are going to be in trouble. We are going to be in trouble no matter what we do. I suggest we come back here at 2 o'clock, and you will have to be back at 2 o'clock to perform, and is that all right with you, Doctor, or not?

THE WITNESS: Yes, it is all right. Yes, I have an 8 o'clock meeting in my hospital tomorrow which I certainly would like to attend.

THE COMMISSIONER: Yes, but I am just thinking did you have a luncheon appointment?

THE WITNESS: Well I had a luncheon appointment with a person from Calgary but I will have to cut that short.

THE COMMISSIONER: Yes, I think we can go now and we will all be back here at 2 o'clock.

THE WITNESS: Thank you.

--- Luncheon Recess.



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AA: 2

DM:

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--- Upon Resuming at 2:00 p.m.

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THE COMMISSIONER: Now Dr. Fay tells me that he has cancelled his meeting for tomorrow and also his departure on the train so we have no great rush, I do not want you Mr. Olah to take that as a command to lengthen your examination, but we are certainly going to stay until we are finished.

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MR. OLAH: Thank you very much, sir.

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CROSS-EXAMINATION BY MR. OLAH (Continued)

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Q. Doctor, before lunch we were discussing a series of deaths, and essentially what we were doing was looking at it from a different perspective?

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A. Yes.

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Q. And I would like to continue that travel together.

A. Yes.

Q. And the next child in the chronology would be Kristin Inwood, if we may turn to her. Perhaps the best point of departure is page 222 of the minutes and also page 94 of your documentation.

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A. Page 222 of the minutes, yes.



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Q. Yes, sir. If I can ask you to start at page 222 and the second paragraph under the heading of "Inwood". As you have already indicated, there is a reference to you placing this death in a low suspicious category?

A. Yes.

Q. I take it that was your initial position before you had heard further information from Mr. Cimbura and Dr. Hastreiter?

A. I think that is right, yes.

Q. Now, I take it that what is critical in terms of the toxicological evidence here is the one reading that we have of 491, buttressed by some of the tissue readings?

A. 491, yes. Yes, yes, certainly the toxicology, yes.

Q. Both Dr. Hastreiter and Mr. Cimbura indicated that they were somewhat uncomfortable with the toxicological evidence in this case and that there was some question as to the accuracy of the 491 nanogram reading; am I putting that fairly Doctor?

A. Yes.

Q. So that if we assume for the purposes of our discussion today that that reading



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of 491 is some sort of an artefact, would you be inclined to go back to your initial position Doctor, of this being as a low suspicious category death?

A. Yes. You see initially I called this unlikely, and then Dr. Hastreiter says, according to these minutes:

"... based on clinical findings, he put this death in his "Good" category."

Which means A, B or whatever, you know at least probable category according to that, that was his "Good" category. But I placed it in the unlikely category and there is no question that I put it into the low suspicious, in fact I have written "Consensus low suspicion" on my yellow ticket and that surely was, apart from anything else, to an extent based on the toxicology.

Q. But coming back to the question I directed at you, Doctor.

A. Sure.

Q. If we removed that one reading of 491, are you then placed back into your initial opinion of low suspicion?

A. My initial category was unlikely



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in fact, or low suspicion, yes.

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Q. But again I would just like you to assist me if you can. If we take out that one reading, and on the basis that it may be - there may be some contamination there, are you then back to your initial position of unlikely or low suspicion?

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A. Well there is this myocardium: "... a minimum estimate of the concentration in the heart before fixing was 549 mg."

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And I really don't know what that means.

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A. I think if you are going to take the toxicology away I would agree with you.

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Q. Well I am not trying to take all of the - I guess I am trying to sort of go halfway on that, Doctor.

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A. Yes.

Q. Because the tissue readings are there and they have to be dealt with.

A. Yes.

Q. But there has been some suggestion that the serum reading of 491 may be the result of either contamination or some artefact. If we take that one reading away, my question to you



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is what are you left with?

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A. I don't know what we are looking at in the other values to be quite honest with you.

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Q. Well did not Mr. Cimbura indicate to you that tissue readings alone are helpful in terms of the presence or non-presence, but that really they are of very little assistance in coming to some sort of a conclusion as to the level to be extrapolated back.

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A. Yes, yes.

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Q. So bearing that in mind, and assuming some sort of an artefact with respect to the 491 reading?

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A. Yes.

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Q. Are you not driven back to your initial position, Doctor?

A. Well I certainly alter my opinion from "unlikely" to "low suspicion" after I have heard the people who were at that meeting going over this, over this data. So presumably I was influenced certainly by that amongst other things, but whether that was the figure which was most influential in my analysis I can't tell you now.

Q. I am not asking you about that.



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A. No.

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Q. I am not asking you about the procedure or the process you went through on September the 13th.

A. Yes.

Q. I am asking you today; assuming hypothetically that that 491 reading is - there is some problem with it?

A. Yes.

Q. All right, if we take that away, what would your position be today, Doctor, with respect to the death of that child?

A. Well I think - can I put something to you? If I am presented with this code, and I am asked a question, even if I am asked a question, I think I am going to say as I did initially "unlikely".

Q. Fair enough.

A. Is that --

Q. That is exactly what I was trying to ascertain.

A. Yes.

Q. Let's then move on to the other child who died in that time frame, and that is the Hines child, and the discussion of the Hines child



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commences at page 220, Doctor. Doctor, I am just wondering whether in the Hines case, given the pathological diagnosis of SIDS that we have heard about, or missed-SIDS culminating in SIDS; and given the finding of digoxin in the fixed and exhumed tissues of the child, are you not left with the similar kind of situation you had in Belanger and in Lombardo; namely, it may have been digoxin, or it may have been natural causes?

A. Yes, yes, yes, I think I would agree with you.

Q. Let's then move to Kevin Pacsai. Doctor, you have not had the benefit I don't think of the evidence that we had with respect to the forensic toxicology, but there has been some reference to a pathophysical situation in the Gary Murphy case. Are you familiar with the Gary Murphy case?

A. Yes, I know something about it.

Q. That was a range of digoxin readings very similar to the Pacsai reading I understand? I am sorry, you are going to have to say yes or no.

A. Well I don't understand that



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2 because I have not gone over it in detail, I haven't
3 got the figures before me of the Gary Murphy case,
4 so I am taking, you are informing me, I didn't know
5 you were questioning me.

6 Q. The post mortem digoxin assay
7 result was in the neighbourhood of the Kevin Pacsai
8 case, do you know that?

9 A. Yes, I did hear that, yes.

10 Q. And the explanation as I
11 understand ultimately reached for the death of
12 Gary Murphy was one of a pathophysiological
13 explanation for the elevated digoxin reading. Now
14 of course you didn't have that theory or that
15 scientific explanation available to you when you
16 did your review because that is a fairly recent
17 phenomena that has been catalogued.

18 A. Yes, that's true.

19 Q. Would you agree with me, Doctor,
20 that given that new theory that it may be also
21 applicable to the Kevin Pacsai case?

22 THE COMMISSIONER: Before you describe
23 the theory you have to describe the whole of it.

24 MR. YOUNG: You have to talk about
25 the fact that this baby did not have a spleen,
and you go on and on and on, a very unique child.



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THE COMMISSIONER: Yes. It is difficult, if you are going to put that sort of thing to the doctor, I don't know whether you may be familiar with it or not, but we had all sorts of evidence as to the fate of the Murphy baby, and it is a different disease than the Pacsai baby. I don't say what was true in Murphy couldn't be true in Pacsai but you cannot say they are identical.

MR. OLAH: I didn't suggest that.

THE COMMISSIONER: No.

MR. OLAH: But perhaps I should rephrase my question and assist the doctor this way.

Q. Doctor, the explanation as I understand it in the Murphy situation was that even though there was a discontinuation apparently of digoxin a very elevated post mortem digoxin reading was ascertained, or found?

A. Yes.

Q. Are you familiar with that?

A. Yes I understand the bare bones of what you are telling me, I don't know any of the details about this.

Q. I am just wondering, Doctor, if a similar phenomena were to account for the



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elevated post mortem digoxin reading in Pacsai -

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THE COMMISSIONER: You can ask this

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question but the answer is worthless, that's all.

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I'm just saying that to you because you have to

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compare the two babies. The theory as I understand

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the Murphy baby was that there was the death of

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tissue and the release from the tissue even during

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life, there was a death of tissue and a release

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from the tissue of digoxin.

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2 So if you are going to compare the Pacsai baby to the
3 Murphy baby you would have to have the same problem
4 with the Pacsai baby of which there is no evidence.

5 Now maybe I am wrong. Maybe I didn't
6 understand.

7 MR. OLAH: There is some evidence of
8 that, Mr. Commissioner, I believe. The autopsy, if
9 I may have your indulgence for a moment...

10 THE COMMISSIONER: I don't mind you
11 putting a question to him but I really don't want
12 Dr. Fay to give his opinion on this which he is quite
13 certain and he is perfectly clear, he is not an
expert on that subject.

14 MR. OLAH: I wasn't going as far as
15 my friends had apprehended, but simply the question
16 I was going to put to the Doctor:

17 Q. Given that new explanation for
18 elevated digoxin readings, Doctor, in post mortem
19 tissue, would that have some impact upon your opinions
as to causation of death in the Pacsai case?

20 THE COMMISSIONER: Yes, Miss Cronk?

21 MS. CRONK: Sir, the point has
22 already been made. How could the Doctor in all
23 reasonableness be asked to reply on that without
24 knowing what the circumstances were that gave rise
25



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2 to that explanation?

3 THE COMMISSIONER: Well, Doctor, do
4 what you can with this but bear in mind the opinion
5 has been expressed here that you are not getting all
6 the facts, but do what you can.

7 THE WITNESS: Well, it is known that
8 I am not a toxicologist because I have said so. It
9 is known that I am not a clinical pharmacologist
10 because I have said so.

11 I have also stated to you that I know
12 the bare bones of the Murphy case. Unless you are
13 prepared to give me all the details --

14 MR. OLAH: Q. Fair enough, Doctor.

15 A. -- all the information and time
16 to go over that and compare and think again, I don't
17 know what I am going to answer to you.

18 I can tell you this, that there is
19 no question that there has been a great resurgence
20 in interest in the pharmacokinetics of digoxin and
21 digitalis compounds. That is obvious.

22 And the fact it appears that some
23 new information has emerged in the last year or so
24 from when this study was done doesn't surprise me one
25 little bit, but I really can't answer your question.

Q. I think that is a fair answer



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and I am content to leave it at that, Doctor.

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The other child I wanted to deal with
briefly was the Miller child.

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A. Yes.

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Q. And the Miller child is found
in your notes, Doctor, commencing at page 98.

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In reviewing your notes on the Miller
baby I was wondering - I didn't see any reference
to resuscitation associated trauma being noted. Is that
something you noted from the final autopsy report,
Doctor?

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A. Did I note resuscitation
damage?

14

Q. Yes.

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A. I don't make any note of that
here. I don't see it.

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MR. OLAH: Could we see Exhibit 115,
please, Mr. Registrar?

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I would like to refer the Doctor
to page 52, Mr. Commissioner, the final autopsy
report.

21

THE COMMISSIONER: Exhibit?

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MR. OLAH: Page 52 of Exhibit 115.

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Q. On their anatomical diagnoses,
Doctor --



Fay, cr.ex.
(Olah)

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A. Yes.

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Q. -- you see under 5 associated
trauma.

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A. Yes.

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Q. Was that something that I assume
you noted during your review of the chart?

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A. Oh, I saw that, yes.

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Q. And I think you have already
told us that by September 13th, 1982 you had some
familiarity with the concept of digoxin leaching
out of tissue into the blood stream?

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A. Yes, that is true.

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Q. I'm just wondering, Doctor,
was that issue ever discussed with respect to this
child about resuscitation associated trauma possibly
causing some leaching out of digoxin and resulting
in elevated digoxin readings post mortem?

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A. I don't think so. I don't
remember it.

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Q. Is that something that in your
opinion may have some bearing upon assessing the cause
of death of this child, Doctor?

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23

A. Well, first of all, resuscita-
tion chest trauma is not unusual as you know.

24

25

Q. Let me assist you just for a



1
2 moment if I may.

3 We have heard evidence that approxi-
4 mately 98% of digoxin in the body is found in tissue.

5 A. Yes.

6 Q. And approximately half a per
7 cent in blood serum?

8 A. Yes.

9 Q. And that a very small amount
10 of leaching or migration from tissue to blood serum
11 can cause a very elevated serum reading?

12 A. Yes.

13 Q. I am just wondering whether
14 in retrospect that has any bearing upon your
15 assessment of the cause of death of this child?

16 A. Well, of course if you give
17 me new information and you ask me does it do this
18 or that in my estimation, then clearly my whole
19 training is to accept information and to look at it
20 again if I am asked to do that, so of course I will
21 look at it again.

22 But this baby had arrested, isn't that
23 so, and the question was why the baby arrested.

24 What relationship the high post mortem
25 digoxin level had to the resuscitation attempts I
really don't know, but I suppose it could have



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affected them.

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Q. Okay. Doctor, I guess the point I am trying to make in a very heavy torturous way is this: that if one looks at the number of deaths from a different perspective --

A. Yes.

Q. -- from that different periscope that you talked about --

A. Yes.

Q. -- are you not equally in many of the cases driven to a very different conclusion than you had reached in September of 1982?

A. I don't know that I am driven to anything, but I am certainly - I would certainly be prepared to grant you that I might have a different opinion, yes.

Q. And that if one doesn't have that presumption, that initial presumption, that it may well be that many of these deaths in fact are natural and not caused by intentional administration of digoxin?

A. Would you say that again, please?

Q. Many of these deaths that you and I have reviewed starting with Lombardo through to



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Miller are explicable by something - if you start from a different premise?

A. Yes.

Q. Many of these deaths may well be explicable by an innocent explanation that is a natural explanation rather than the intentional administration of digoxin?

A. I don't think that there is any if you are asking me as a clinician which you clearly are as it is the only way you can ask me, interested in heart disease treating patients with heart disease, if you ask me that and put that to me then I suppose I have to say yes there is.

But you are certainly taking me into an entirely different setting when you - I am trying to place myself at your request I might say in an entirely different setting, and it isn't the easiest thing in the world, you know, to do what you are requesting either.

Q. I appreciate that.

A. But I grant there is a measure of veracity in what you are saying, yes.

Q. Well, I just want to know how much of a measure of veracity we are talking about because it becomes fairly important to us.



BB8

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Would you agree with me that certainly
in the deaths we discussed, Belanger --

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A. Yes.

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Q. -- Lombardo, Estrella, Hines,
that there may well be a very different perspective
shed upon those deaths when you are looking at it
from a different initial presumption?

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A. Yes, I think I would agree
with that, yes.

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Q. And similarly with the Miller
death when you look at the element that wasn't
discussed on September 12th, 1982, the resuscitation
trauma may shed a very different perspective on that
death also?

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A. Yes. I don't remember that
being discussed and it is possible that it did
influence substantially, I suppose, but again this is
an area where I am not expert, and I really can't
give you a terribly satisfactory - a very satisfactory
answer because of that.

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Q. All right. I have two brief
matters, other matters, I would like to discuss with
you, Doctor.

Reading between the lines from the
minutes of the meeting of September 12th, 1982, what



1
2 occurred was that discussion primarily conducted by
3 you and Dr. Hastreiter and to some addition by
4 Mr. Cimbura of the anatomy of the children and the
5 toxicology evidence?

6 A. I think that is about the size
7 of it, yes.

8 Q. And from time to time you had
9 assistance from Dr. Gilmour-Bryson also about certain
10 specific sets of facts; for instance, what nurses
11 were on duty and at what time?

12 A. I think that would have been
13 the area she might have been dealing with. I don't
14 know. I can't remember the details.

15 Q. Doctor, I suggest to you that
16 the name of my client, Janet Brownless, did not
17 come up during the course of those discussions with
18 respect to these children?

19 A. I can't remember the name.

20 Q. Do you remember the names that
21 were discussed without naming the names?

22 THE COMMISSIONER: Well --

23 MR. OLAH: I don't want the names,
24 Mr. Commissioner. I just want to establish the
25 negative.

MR. BROWN: Well, Mr. Commissioner...



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THE COMMISSIONER: I think it is most unlikely that you would remember the names and I don't really know - he said he does not remember your client's name. Can't we leave it at that?

THE WITNESS: I can't remember the names that were discussed. I don't even know that names were discussed.

Certainly the people that you have mentioned were all present. Certainly matters other than what I was just talking about and Dr. Hastreiter was talking about and Mr. Cimbura was talking about were mentioned but I don't think at any great length, and I can't remember the names.

MR. OLAH: Fair enough, Doctor.
Thank you for your assistance.

THE WITNESS: Thank you.

THE COMMISSIONER: Mr. Labow?

Are you going first?

MR. SHANAHAN: Sir, I think that Mr. Labow is scheduled next, but I have to leave early and I don't know how long Mr. Labow will be so if I might I would like to squeeze myself in.

THE COMMISSIONER: You don't object to that?

MR. LABOW: I don't object, no.



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THE COMMISSIONER: I have a feeling that the missing Mr. Tobias might have some more to say on this but I guess we won't complain.

CROSS-EXAMINATION BY MR. SHANAHAN:

Q. Doctor, my name is Shanahan and I act for the families of the Lombardo and the Dawson children.

A. Thank you.

Q. One of the things at the outset, Doctor, you have been at pains to emphasize the way that you were, if you like, retained and the scope of what you were addressing your mind to at the time.

Would it be fair to say at that particular point in time you were responding to enquiries from the Crown Attorney's Office and that your purpose really was to look at it and to come up with some sort of outside opinion on the possibility of digoxin intoxication here?

A. Yes. I think that when Dr. Ross Bennett phoned me he indicated it was the Crown Attorney's Office that wanted another opinion and asked me would I look at these charts of these children and would I attend this meeting which was coming up very shortly, so it must have been some time near to June 30th I suppose.



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Q. Yes.

A. Which was the first meeting
I attended.

Q. And obviously you at that time
weren't aware and couldn't have been aware that the
opinions you would come to there and the subsequent
alterations or change as you met with other of your
confreres on September 13th, you couldn't in any way
know that much later at a Royal Commission here you
would have these opinions of yours gone through with
a fine tooth comb and be asked to justify them in
the light of new and changing circumstances.

THE COMMISSIONER: If you say you
were aware you will certainly surprise me.

MR. SHANAHAN: Q. If you were aware
you knew more than Mr. McMurtry, but you didn't
know what we are going through here, this exercise,
would really put your report and your conclusions
there under scrutiny that we have had the last few
days?

A. Well, I am sufficiently senior
in my profession and I have had sufficient encounter
with members of your profession that I know any time
I write anything down on a bit of paper it is likely
to get into one of your members' hands and I may be



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called to account for it. But if you are asking
me did I have any idea of the fineness of the comb
that was going to be dragged through my hair, no,
I didn't.



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Q. And in fairness to you too, sir, I gather as I see you answer here in the last few days that you feel now in retrospect that the way in which you were forced to look at these and make your contribution to the September 13th meeting was perhaps restrictive and too restrictive for you and that that's why as you gathered more information from Hastreiter and other factors from Dr. Gilmour-Bryson and things of that nature, more added to that total pool of knowledge that you had and, therefore, your opinion could alter and could change?

A. Yes, it was restrictive. I was, I think it is true to say, left very much to my own devices and on my own. In retrospect I think that I am pleased that it went that way, but that's the way it did go.

Q. All right. And it seems obvious, but Mr. Strathy put to you, you didn't see these people and you didn't have clinical observations, you only got to look at their notes. But in fairness to you, sir, a lot of the other factors that we have subsequently heard you weren't told about either; for instance, it strikes me that you were never told, for instance, about, we will say,



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2 the predominance of these babies dying at a given
3 time of the day or night, was that ever really
4 laid in front of you?

5 A. Oh, yes, that particular
6 point was that there was a preponderance -- there were
7 two points. The deaths that I reviewed had all oc-
8 curred within a certain period, I knew that from
9 what I was told and there was a preponderance of
10 deaths at a certain hour, between certain hours.
That I did know. It came out.

11 Q. All right. Let me put it
12 to you here, sir, that in terms of arriving at your
13 opinions and for instance your shift in opinion with
14 respect to Lombardo and others, that really for you,
15 to put to you here, sir, if I give you other factors,
16 quite apart from your being a doctor, just as a layman
17 here using your common sense I put to you that many
18 of these deaths for instance were happening at
19 a similar time of night, that many were happening
20 on the same ward, many were happening here with the
21 same nursing team, but obviously being on the same
22 ward they were all roughly the same age bracket.
23 But within that time period we have seen a rise in
24 the number of deaths and we even have evidence here
25 of head nurses going to some of the doctors to express



1
2 a feeling of bewilderment that their patients are
3 dying who are not supposed to die at that particular
4 point of time.

5 When you unite all those factors
6 together, sir, with respect, it even makes the
7 conclusions that you reached seem tame.

8 A. Well, I'm sorry if I appear
9 tame, I didn't mean to.

10 Q. Well, I put to you that all
11 of those factors, in addition to the toxicology and
12 in addition to the clinical observations that you
13 made, if you join them all together they certainly too
14 have an influence on any decision someone would
15 make with respect to those deaths.

16 A. Yes. The only thing I would
17 like to say there, if I may, I think it has some
18 bearing, is that although I knew of those factors
19 and they were discussed, I don't think those
20 factors really entered into my chart survey.

21 Q. Yes.

22 A. Do you know what I mean?

23 Q. It is exactly what I thought.
24 In fairness to you, you were told to look at the
25 records, you had a room there, people were just names
to you, you were reviewing symptoms and coming to a



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decision; some you didn't even have the toxicology
until very late in the day.

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A. Right.

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Q. But certainly all of those
other attendant circumstances that we have heard,
you didn't know all of them then.

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A. I don't think I know all of
them now.

9

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Q. Well, hearing them now and
me telling you now.

11

A. Yes, yes.

12

Q. Doesn't that too influence you
as a layman looking at these occurrences of deaths?

13

A. Well, it has, hasn't it.

14

Q. All right.

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A. I mean, it has influenced
others, it has been one of the factors, as I understand
it. You are asking me a really non-medical question.

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Q. Exactly.

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A. That's not a medical question.

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Q. Your question and what you
were asked to look at was a medical one and an isolated
factor.

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A. Yes.

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Q. But if you bring all of these

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2 matters to bear, I am suggesting to you that as a
3 medical man or as a layman you would be influenced
4 by that other occurrence of circumstances?

5 A. Well, I suppose we've gone
6 through that in the general sense of the way that
7 I came into this. I don't know how one can dissociate
8 every single bit of this, but it certainly wasn't
9 something that I had here as a list that I checked
10 against the chart when I reviewed the chart. I re-
11 viewed the chart. I reviewed it as I was asked to
12 review it, was there a possibility in this case that
13 the child could have died of digitalis overdosage
14 or could have contributed.

15 Q. I put it to you, others here,
16 Mr. Roland and maybe Mr. Olah for sure and Ms.
17 Chown have asked you to look back here and asked
18 you to put on these glasses, but I would put to you,
19 sir, that if you look back there in any other way
20 other than taking into account all of the factors
21 that really you are looking back there with blinkers
22 on and not really with any particular new set of
23 glasses at all, to take them in isolation really is
24 to be naive. Don't you think those factors are
25 crucial and they are important?

A. But you are asking me now,



Fay, cr. ex.
(Shanahan)

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really, you are really asking me out of my area of
expertise immediately, aren't you?

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Q. Not really out of your area
of expertise. I mean, bear in mind that you work in
a hospital, you deal in cardiology. If you saw all
of these factors-- Dr. Rowe said he had never had
nurses come to him complaining before, never seen
that in all his experience. The predominance of the
shift, the predominance of the times, predominance
of the ward, predominance of the age bracket and that
rise in epidemic we've heard, that when you unite
that with the toxicology and unite it with all the
other factors, that that really would certainly
influence anybody, be it a layman or medical man
like yourself.

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A. Yes, it would, but if it hap-
pened within my own practice it would certainly be
something that I would be taking note of and be
concerned about, just as I hear Dr. Rowe has stated.

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Q. All right. Sir, with respect
to the clinical ---

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MR. KNAZAN: Mr. Commissioner, I
don't like to interrupt anybody's cross-examination,
I'm not going to, but I strongly object to this line
of questioning, I think it is argumentative and I



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2 think it deserves your rule. I have a list of places
3 where it has occurred before and I have been restrain-
4 ing myself from bringing it to your attention. If
5 you would give me three minutes when Mr. Shanahan is
6 finished I would like to address you on it.

7 THE COMMISSIONER: No, no, I don't
8 know that I will give you three minutes. I am quite
9 capable of knowing what is cross-examination and what
10 is argument and I have given up trying to confine
11 people to one or the other.

12 MR. KNAZAN: Well, give me half a
13 minute because, you see, some people I think are
14 restraining themselves and other aren't. For instance,
15 I could have asked Dr. Fay and I could have asked
16 Doctor -- the pharmacologist, I'm sorry -- MacLeod,
17 and I didn't. I could say, Doctor, do you think it
18 is likely someone would know that every one of these
19 would have a clinical knowledge to know that every
20 one of these children had a heart disease which
21 could have caused their death, but there is no
22 anatomical findings in pathology for digoxin, that
23 it would have been likely for this, that if
24 a reading had come back of 72, and that a doctor
25 could have said this, and I could go on and on, but
it is useless, that is for you to decide.



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2 THE COMMISSIONER: Well, I know,
3 I know, but I am not going to stop him, I am not
4 going to stop him. Since time immemorial people have
5 been putting argumentative questions in cross-
6 examination. I don't know of any judge that knows
7 how to stop them. Sometimes it does some good because
8 it doesn't get the answer that you want from the
9 witness, but sometimes the judge reacts and people
10 have been doing it since I don't know how long;
11 certainly as long as I have been around people have
12 been doing it and I am not going to make a new rule
13 for Mr. Shanahan, that's all.

14 If it goes on too long sometimes I
15 sigh a bit and suggest maybe he could get on with
16 something else but for the moment I am just going
17 to leave it.

18 Yes, Mr. Olah?

19 MR. SHANAHAN: I have touched a nerve
20 here, I've touched a nerve.

21 MR. OLAH: I would point out with the
22 greatest of respect this witness is an expert witness
23 and we are here to test his opinion on the basis
24 of his expertise and information available to him.

25 THE COMMISSIONER: That is the way
with all expert witnesses.



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MR. OLAH: Yes, sir.

THE COMMISSIONER: The same thing I said before still applies.

MR. OLAH: And this line of cross-examination doesn't go to his expertise at all, with the greatest of respect.

THE COMMISSIONER: Thank you. Would you carry on, Mr. Shanahan.

MR. SHANAHAN: Yes, sir.

Q. With respect to the symptoms here, Mr. Olah and Mr. Roland have made much of the fact that all of these symptoms are non-specific, you know, vomiting in small children and many of the other symptoms. But surely they may be non-specific but they are not worthless in terms of assessing the child's condition, are they?

A. In terms of assessing -- well, I would certainly be terribly concerned about a profound bradycardia or a tachyarrhythmia in a sick baby.

Q. Dr. Rowe has said to us that in fact really the chief, if you like, criteria that he used is to see if a child is moving from that therapeutic region into slight overdosage is really the clinical observations. He starts to look at the



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vomiting, the lethargy, your arrhythmia problems
and things of that nature. So, they may be non-specific
but clearly they are important, aren't they, that's
what Withering said in the 1700's, he said it acts
on the pulse or the urine or the bowel. Yes,
clinical observation is very important to a
clinician, yes.

Q. All right. But more than
that, with respect to digoxin, and I'm not just
talking about the clinical condition here, the
symptoms that Mr. Roland went through, bradycardia,
vomiting, ventricular fibrillation, arrhythmias,
shallow respiration and lethargy and he said to
you, well, they are non-specific. They may be non-
specific but if you are looking for clinical symptoms
and observations about digoxin, they are the very
things you have to look for.

A. Well, that's what I did.

Q. No, I appreciate that.

A. Yes.

Q. But I am saying to you that
they are not worthless in terms of coming to an opinion
about whether a child is becoming intoxicated by this
digoxin.

A. Well, I wouldn't have been



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2 writing them all down if I thought they were worth-
3 less.

4 Q. All right. Again, sir, in
5 terms of the number of symptoms that we might see
6 in a child's chart here, and you have done this,
7 I'm not criticizing you here, but the more of those
8 symptoms that a child would enjoy or share or
9 show would really indicate even more strongly, quite
10 apart from blood readings, quite apart from toxicology,
11 but up there on the floor before you even have those
12 readings, that the more of those symptoms that the
13 child would display, the more one could assess
whether in fact there was a digoxin problem.

14 A. Well, I'm not sure. You
15 know, you can't have your cake and eat it. If
16 they are non-specific they can be more or less
17 severe according to whatever is causing them. You
18 know, I don't think you can have it both ways.

19 Q. You can't have it both
ways, but I am concerned here --

20 A. No, I mean, I can't have it
21 both ways, I didn't mean you.

22 Q. All right. We have seen
23 doctors make comments on the record here and
24 be concerned about digoxin, we know they don't get
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tested every single day.

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A. No.

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Q. And I'm saying to you then

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that as you are on the floor dealing with a child

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who is on digoxin and you see these symptoms,

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and not just one, if you just saw vomiting you may
put it down to any number of things.

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A. Yes.

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Q. But when you start to see

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a number joining together they may be non-specific

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but they are not worthless, they do tell you some-
thing.

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A. No, not at all, not at all

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worthless.

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Q. All right.

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A. Very important.

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Q. All right. In terms of

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toxicology as well, we have heard made mention here

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that at some point in time the Hospital for Sick

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Children didn't further babies exhumed, the heartache

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that this might bring and the fact that the results

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of the testing of the exhumed tissue might be so
uncertain.

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MR. YOUNG: Excuse me, Mr. Commissioner.

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MS. THOMSON: Excuse me, Mr.

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Commissioner.

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MR. YOUNG: I'm afraid I must interrupt my friend. I don't recall that being the evidence. Dr. MacLeod made a statement that he believed that the exhumation should stop but I don't recall him saying anything further and, indeed, the exhumations did stop.

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THE COMMISSIONER: Yes, all right.

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MS. THOMSON: I would just make the same comment, Mr. Commissioner.

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THE COMMISSIONER: All right. I don't remember that evidence at all. Can you point to something?

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MR. SHANAHAN: All right. Well, that may be a better framing of it, that Dr. MacLeod felt that the exhumations should stop.

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A. I didn't know that.

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MR. OLAH: It was Dr. Fowler.

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THE COMMISSIONER: Dr. MacLeod, was it?

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MR. SHANAHAN: No, Dr. MacLeod did, too, I'm quite sure of that and I think Mr. Young recollects that.

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MR. YOUNG: That was my recollection, yes.

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MR. SHANAHAN: Q. Dr. MacLeod clearly said that it was his feeling the exhumation should stop.

If you will agree, sir, that if we didn't have here, if you hadn't exhumed tissue of Lombardo, if you didn't have exhumed tissue of Belanger, that without the toxicology that Mr. Cimbura gave us from that, we would really be at sea in terms of trying to assess whether Lombardo, Belanger, for that matter, were deaths from natural causes or whether in fact digoxin had some role to play, wouldn't we?

A. Yes, yes,

Q. I think in fairness you gave in your evidence about Lombardo that one of the chief reasons that makes you change your opinion, upgrade your status is that at the meeting both yourself and Mr. Cimbura, Hastreiter, that toxicology, that data simply can't be gotten around.

A. Well, I believe that is what I said.

Q. All right.

A. That I was taking it very much into account.

Q. And we have been told, sir, that



Fay, cr. ex.
(Shanahan)

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with mass spectrometry that it is quite clear they are confident that in fact it is digoxin and not digoxin-like substances, all right?

A. Yes, yes, I heard that.

Q. It is quite clear that Lombardo was not on digoxin and therefore it must have been administered during her life.

A. Yes.

Q. And it is quite clear at the very least we've got a mistake with respect to Stephanie Lombardo.

A. Yes.

Q. And if we didn't have the exhumations and the toxicology we wouldn't have at least that much information there, would we?

A. No.

Q. All right. I might say, too, it seems that counsel here have by inference got at, if you like, the limitations that you had upon you, but Volume 18, Page 3275 of Dr. Rowe's evidence.

May I ask your indulgence here, I am just getting assistance from all corners.

THE COMMISSIONER: Well, it is always nice to have a friend.

MR. SHANAHAN: I didn't think I had



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any, sir.

All right, I just want to put to you here to clarify for the record, but I don't think you will have much further comment, with respect to that question I put to you about Dr. MacLeod.

THE COMMISSIONER: What is it you are looking at?

MR. SHANAHAN: That is contained in Volume 64 on Page 4463, I think. Ironically, it is in the cross-examination of Mr. Olah.

MR. OLAH: That explains why I didn't remember it; obviously I didn't make a note.



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MR. SHANAHAN: You didn't read the transcript.

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Q. In any event, here, starting at page 4463 you give an answer to Mr. Olah's question somewhere around the middle of the page:

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"Q. It was somewhat less, as I recall it was probably about the same because they both died the same, about the same time frame, I think Lombardo died a week or two later."

11

And there is a long answer.

12

A. Who is this?

13

Q. Dr. MacLeod.

14

A. Yes.

15

16

Q. Mr. Olah puts that question to him and Dr. MacLeod gives an answer here and I will read this answer and he says:

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"A. Again it really - I think it would be very imprudent to try to interpret these in any way." -

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That is the readings of digoxin in exhumed tissue.

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Q. "Clearly these concentrations reflect an element of dehydration or desiccation, tissues that may reflect



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"post mortem bacterial colonization of the body and destruction of digoxin by bacteria, a completely unknown factor to us, and they also reflect the fact as is evident in any of the post mortem tissue studies that have been done that there is a twentyfold variation in the kinds of tissue concentrations that you achieve after a standard dose."

This is the part of the evidence that I was putting to you here:

"So, I mean, how could one expect to interpret these differences in post mortem tissues. In fact, it is this intrinsic uninterpretability of post mortem tissues that led us to believe that the police and the coroner should stop exhuming bodies, those results cannot be interpreted other than in a strictly qualitative sense as we have tried to do this morning."

I think that is what I was getting to you is that somebody there didn't want them exhumed. I am saying to you just exhuming them itself was able



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to give you proof that there was digoxin in some of these children.

A. Yes.

Q. And had they not been exhumed we wouldn't have that.

A. No.

Q. Now about Dr. Rowe, in terms of the cases that you have put in that top category, sir, and I think again that maybe there had been some inference by some that there is other explanations and that your highest, or your most certain category isn't necessarily valid here.

Dr. Rowe, though, just to be of some comfort to you, in Volume 18, page 3275 was asked by Mr. Lamek what he finally concludes of all the deaths

THE COMMISSIONER: We have had that already, I think, isn't that what was read to us this morning?

MS. THOMSON: That was the part of the quote that Mr. Roland put to the witness this morning.

MR. SHANAHAN: Q. I just wanted to put to you here that Mr. Roland put that to you, but to be of some comfort to you even though you were looking at it in the restrictive way you were, that



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those people who were actually dealing with the children in the hands-on treatment of the children to a large extent with the exception I think of Velasquez and Belanger and the interchange there, Dr. Rowe concurred that these children were very high probability of death by overdose of digoxin.

MR. OLAH: I don't believe that was the evidence, the high probability related to Cook and the others had to be examined by people who knew more about it.

MR. SHANAHAN: This is what I wanted to read out.

THE COMMISSIONER: Dr. Fay has had it read to him, anyway, I don't think --

MR. SHANAHAN: Q. Sir, with respect to specifically then the children that I act for in terms of Lombardo here. Some of the factors that I wanted to point out to you here and one of them is Dr. Hastreiter's comment, do you have Exhibit 261; Lombardo is dealt with at page 225.

THE COMMISSIONER: Are we talking about the minutes?

MR. SHANAHAN: I am sorry, the minutes.

THE COMMISSIONER: Oh, I see, all right.



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MR. SHANAHAN: Exhibit 261, the
minutes.

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THE COMMISSIONER: Yes, all right.

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MR. SHANAHAN: Q. With respect to
Lombardo the comment made after the notation there
about the vote, you vote "probable murder";
Dr. Hastreiter votes "probable murder" and the
comment:

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"Child was doing reasonably well after
surgery; was not supposed to be
receiving digoxin, and high digoxin
levels were found in all tissues."

13

And then he makes the comment:

14

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16

"If the child received a maintenance
dose accidentally, there would not be
these levels."

17

A. Where are you now?

18

Q. Page 225.

19

A. Yes.

20

Q. Right down at the bottom.

21

THE COMMISSIONER: Right at the bottom,
right at the vote.

22

THE WITNESS: Yes, I see, yes, thank
you.

23

24

MR. SHANAHAN: Q. And the last
sentence:

25



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3 "If this child received a maintenance
4 dose accidentally, there would not be
5 these levels."

6 Now, you have indicated here to others,
7 I mean to Mr. Roland and Mr. Roland to you, that
8 certainly - and you don't hold yourself out to be an
9 expert in these fields. If others come along like
10 Dr. Hastreiter and Dr. Kauffman and can perhaps
11 interpret, or give some interpretation to not only
12 the mere presence of digoxin in a child like Lombardo
13 but how widespread that digoxin is in Lombardo;
14 myocardium, lung, liver, muscle and chest fluid, you
15 would agree that would be an area that you don't have
16 expertise in and could be another factor in helping
17 us decide whether Lombardo was an accidental or
18 deliberate overdose.

19 A. Yes, I would have to listen to
20 experts.

21 Q. With respect to Hines, Hines
22 come up here on page 221, page 221 of that same
23 exhibit, sir. It appears on page 3 that what has
24 happened is Mr. Cimbura in the previous paragraph,
25 or one of the paragraphs has been reviewing the
readings in exhumed specimens of Baby Hines; one of
them is liver, tissue, digoxin concentration of 240



1
2 milligrams per gram. Have you located that in the
3 middle of the page, sir?

4 A. Liver, tissue, digoxin
5 concentration 240 milligrams per gram, yes.

6 Q. All right. I just would tell
7 you myself that the liver concentrations in Stephanie
8 Lombardo, jumping back to page 225 of that were 354,
9 considerably higher than in Hines in the exhumed
10 tissue.

11 Down at the bottom of the page appears
12 to be the summation of what Dr. Hastreiter's comments
13 were with respect to these findings in the exhumed
14 tissue of Hines:

15 "Dr. Hastreiter said that one has to be
16 very careful in interpreting this
17 type of information. However, this
18 child was not supposed to be receiving
19 digoxin therapy. If the child received
20 a maintenance dose by mistake,
21 Dr. Hastreiter stated that the levels
22 are way beyond his findings for
23 therapeutic levels in the liver, and
24 it would suggest to him quite strongly
25 that this could not have been just one
accidental maintenance dose."



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3 Now, would you agree when you tied
4 that comment as well in with the Lombardo liver
5 readings, that really there is a strong suggestion
6 in here, quite apart from Lombardo clearly having dig.
7 in her tissues, that there was clearly a suggestion
8 from Hastreiter there at that meeting that Lombardo
9 had died as a result of a dig. overdose and it was
10 not one mistaken therapeutic dose.

11 A. Certainly I was in no position
12 to argue with such comments of people who had more
13 experience of this particular subject than ever I did.
14 My experience I have told you as a clinician who
15 has used this drug, and who gets serum digoxin
16 concentrations on his patients and follows them and
17 so forth and knows that there is always a danger of
18 dig. toxicity in a patient receiving the drug. I
19 am not expert in this field, of course I have to
20 pay attention to what the experts are saying.

21 Q. Sir, finally then with respect
22 to Dawson; I think one of the things you indicated
23 in the transcript was with respect to Dawson you did
24 not see or review any autopsy findings. I can give
25 you the page and reference number you gave us yesterday,
but if you recollection that yourself you didn't
in fact review or you didn't see for whatever reasons



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her autopsy results, and we are on common ground.

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A. No, no, no, I didn't, I didn't have any note of autopsy findings which I have made in the other children where I saw them. Then I was told yesterday that the autopsy showed perforations of the stomach, that was new information to me.

8

Q. Right.

9

10

A. I don't think I reviewed the autopsy findings in this child, I said so yesterday.

11

12

Q. I just wanted to clear the air. I have a place here where you said you didn't see them and that is fair enough.

13

14

Can I tell you, sir, if you could look at Amber Dawson's medical chart?

15

A. Yes.

16

17

18

Q. I think it is Exhibit 69 and that starts at page 59 and the page I am going to refer you to starts at page 63, have you located page 63 in her medical record, sir?

19

A. Yes, I have it.

20

21

Q. And in paragraph 7, sir, the "Summary of Abnormal Findings", it reads here:

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"The autopsy showed that the surgical repair of congenital heart defects has been successful. Ventricular and



1
2 "septal heart defects have been closed
3 and appeared intact. There was a
4 trivial deformity of the pulmonary
5 valve. Microscopic examination
6 revealed area of old myocardial
7 fibrosis, consistent with ischaemic
8 changes. Gastromalacia with perfora-
9 tion of the cardia was a recent event
10 most likley precipitated by vomiting.
11 There was evidence of pulmonary
12 collapse, but no pneumonitis was found.
13 The presence of focal periventricular
14 leukomalacia is consistent with old
15 ischaemic insult."

16 And then finally the conclusion, the
17 final impression, sir, on the next page, are you with
18 me, that will be page 64 he concludes:

19 "Postoperative repair of separate
20 membranous and inlet ventricular
21 septal defects with excellent surgical
22 result.

23 Trivial deformity of pulmonary valve
24 with nodular thickening in the free
25 valve margin, probably secondary to
previous pulmonary artery banding.



1
2 "Previously repaired main pulmonary
3 artery at site of banding, with an
4 excellent surgical result.

5 Suture closure of patent foramen
6 ovale."

7 Sir, if I was to put out to you that
8 young Dawson here was I think about 11 months of age,
9 perhaps one of the eldest if not the eldest of the
10 children.

11 A. Yes.

12 Q. That Dawson had survived the
13 banding operation at 9 months and had gone on home
14 to her mother and lived at home and received digoxin
15 at the hands of her mother safely over the intervening
16 months. That there was no precipitating event, sir,
17 that brought her back to the Hospital, she simply
18 was not thriving.

19 That she had not undergone any
20 surgery at all at the Hospital. It was perhaps
21 planned to cure her phrenic nerve condition, but
22 other than that it had not taken place.

23 Then suddenly, after a short stay in
24 the Hospital for Sick Children she dies. It was
25 felt she died of a heart condition. Then we have
this autopsy report which indicates, sir, that the



1
2 surgery had been successful.

3 Would you not agree here that quite
4 apart from toxicology, the sudden decline with
5 respect to Amber Dawson is in itself, if you like,
6 suspicious and cause of concern?

7 A. If she had some definitive
8 repair of her defects in May of 1980, as I understand
9 it?

10 Q. That is right, sir.

11 A. And then she died on the 20th
12 of July of that year, having been admitted five
13 days previously, I think that is correct?

14 Q. Yes, sir. Had gone home, had
15 not had any particular attacks that we are aware of.
16 Returns for what is essentially elective surgery,
17 just failure to thrive; is given digoxin at home by
18 her mother, safely, and then dies suddenly and
19 unexpectedly enough that someone in the Hospital,
20 probably Dr. Reynolds feels that the coroner should
21 be notified. This autopsy is performed at the behest
22 of the coroner, and this autopsy report finds that
23 the operation has been successful and that apart from
24 the perforation in the stomach lining, which may have
25 been caused by vomiting, and I will get to that in a
moment, but there is no specific cause of death.



1
2 Isn't that in itself, sir - and you didn't have that
3 then and I appreciate that, but now that you do have
4 it and we have shown it to you do you think that
5 that might raise Dawson out of the low suspicion
6 category?

7 A. Yes, I'm trying to answer your
8 questions as promptly as I can. I really would like
9 to go back and just for a moment read what her
10 condition was when she was admitted.

11 Q. It is hard to locate, sir,
12 because of the fact there are many admissions in
13 various hospitals.

14 A. Yes.
15 I would like to refresh my mind on
16 what the state of Amber Dawson was when she was
17 admitted the 23rd of July, 1980.

18 Q. Her state, sir, or the reason?

19 A. The reason.

20 Q. Well, on page 80 where
21 Dr. Izukawa is doing his final notes and the top
22 line there:

23 "Admitted for assessment of growth
24 retardation of growth despite surgery
25 for patch closure of VSB's and PA..."
I guess that is pulmonary artery debanding:



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"...in May of 1980. Was being considered
for application of paralyzed right
diaphragm."

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A. Yes.

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Q. And then we have that autopsy report at her sudden death.

A. Well, she dies very shortly after admission for what sounds like an elective admission, not an urgent admission, not in acute difficulties. She has a perfect anatomical repair and she has done well since.

I suppose it is the same story. It is really a reassessment, and I don't remember seeing the autopsy report and I think - I don't know why I didn't see that.

Q. Sir then, moving along, her last reading is 1.9 digoxin. That was taken, sir, two days before.

If I could just point out to you here some of the symptoms here which she exhibited in the last few days. On page 80, sir - that is the page you were on.

A. Yes.

Q. And there is a note completed here by Nurse Nelles on July 27th and under behaviour, around the middle of the page - can you locate that, sir?

A. Yes.

Q. Under behaviour, continues to



1
2 be lethargic. Under nutrition, Dr. Reynolds notified
3 re babe poor nutritional status and lethargy.

4 Lethargy comes up many times.

5 Page 85, sir. Nursing notes of
6 July 25th for behaviour. About line 4, sir.
7 Appears drowsy. Slept continuously between feeds.

8 Coming down below, sir, July 26th
9 under behaviour, again by Nurse Nelles, very
10 lethargic all evening. Limbs appear almost floppy
at times.

11 You have Dr. Izukawa describing -
12 I'm sorry I keep turning you around like this, but
13 in her final events here, described the extreme
14 bradycardia, the last two lines of Dr. Izukawa's
15 notes here, arrhythmia; she doesn't recover in any
16 way, shape or form and goes completely asystolic.

17 In terms of the clinical symptoms
18 of Amber Dawson exhibited in the last couple of
19 days, sir, I would suggest to you that although
20 bearing in mind the symptoms are non-specific,
21 bearing in mind the amount of lethargy, the
22 continuous vomiting, bearing in mind that one
23 significant autopsy finding was there was an
24 actual perforation of the stomach lining perhaps
25 because of the persistent vomiting?



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A. Yes.

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Q. That these were two symptoms here which could well indicate to us digoxin toxicity?

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A. Well, you know, lethargy, it is very difficult to know what weighting to give to lethargy.

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That is again one of these very non-specific things. Dr. Izukawa does note although it is an elective admission, he has a note here "No" and then an arrow, an upward pointing arrow, "failure", which indicates to me that she has been in some failure but hasn't increased. So she wasn't that - if that is so, and I presume it is right as it is Dr. Izukawa's note, I presume she wasn't that completely well at the time she came in.

16

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Q. Oh, yes. I concede that to you, sir, she is a sick child.

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A. Yes.
Q. I am just saying without the autopsy report and then looking at those predominating symptoms the last two days, the lethargy and the vomiting, and bearing in mind the perforation of the stomach ---

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A. Which is presumed by the



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pathologist to be secondary to the vomiting.

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Q. That is right.

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A. Yes.

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Q. I am saying to you, sir, that when looked at in that light, her sudden and unexpected death, unexpected enough that the Coroner is notified, in fact when you look at it in that vein Amber Dawson could then have been in the throes of digoxin intoxication?

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A. Well, anything is possible but I must say that I find it difficult to - I find it difficult to really alter my stance and place on that.

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The lethargy, yes, but lethargy again is such a common thing and I don't know whether a lethargic baby really is, you know, in this situation, you said, oh, that is a strong point. Vomiting again is certainly a symptom of dig. intoxication, and I don't really think I could - I would I think have to at this time stay with what I said before.

20

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Q. Bearing in mind that you didn't have the autopsy report then?

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A. No.

Q. And that you do have now;

bearing in mind what it tells you, bearing in mind



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her age.

A. Yes.

Q. The length of time she had been on digoxin from her mother and then her sudden and unexpected death, you still would, sir, and bearing in mind, now, sir, what I put to you today about the other circumstances that we know about the 36 deaths, you would still leave Amber Dawson in that category that you placed her?

A. Well, I am trying terribly hard' to be consistent.

Q. Oh, I know and I --

A. And it isn't easy. I can't remember - I can't remember this autopsy data being brought up or discussed.

As you pointed out everything seems to be intact as far as the cardiac repair is concerned and we know that there are very good anatomical repairs of cardiac defects and children die suddenly from cardiac arrhythmias. That has been well established and I am sure it has been brought out here in these hearings.

Q. Well, it seems to have raised doubt just by the fact that you are taking so long to answer.



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A. Well, it has raised a doubt
but at this time I don't think I am going to alter
my opinion.

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MR. SHANAHAN: Thank you, sir, those
are all my questions.

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THE COMMISSIONER: Well, I think we
will start you off, Mr. Labow but we may have to
break off at about quarter past three if you are
not finished.

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MR. LABOW: That is fine.

THE COMMISSIONER: We certainly will
if you aren't. It doesn't look as though you will
be somehow.

14

15

MR. LABOW: I don't think I will be
finished by quarter after but I think I can deal
with a few of the children.

16

CROSS-EXAMINATION BY MR. LABOW:

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Q. Doctor, my name is Stephen
Labow and I represent a number of the parents of
children in this matter.

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A. Thank you.

Q. Doctor, before I get into
specific children my understanding is that you
reviewed these charts and made your handwritten notes
that we have received a copy of?



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A. Yes.

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Q. And then you made your index

4

cards?

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A. Yes.

6

Q. And then you went to the meeting

7

of September 13th?

8

A. Yes.

9

Q. Now am I correct in thinking

10

that all you took with you to that meeting were
your notes?

11

A. Oh, yes, that is right.

12

Q. And it is possible that you

13

may have made additions, alterations, to your notes
at that time?

14

A. I may - I don't think I made

15

any alterations or additions after that meeting.

16

I think that was it.

17

Q. Now did you make any other

18

notes at the meeting aside from what you may have

19

written down on the notes that we have?

20

A. I think I might have made some

21

notes on the toxicology but I don't know. I didn't
make anything else in the way of notes as far as

22

I remember. The notes that I made at that meeting

23

were on those little yellow cards attached to the

24

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manuscript.

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Q. And then you went back and

4

dictated from those notes your typed version?

5

A. Yes, I dictated and sent it

6

off to Mr. Wiley; not immediately but some time
later.

7

Q. Doctor, I would like to look

8

at Barbara Gionas first. All six medical records

9

that I will be referring to are right beside you.

10

The Registrar has made them available.

11

A. Barbara Gionas, yes.

12

Q. Barbara Gionas. This is page

13

84.

14

A. Of my notes?

15

Q. Of your notes.

16

A. Thank you.

17

Q. Doctor, am I correct in thinking

18

that you put down everything that you thought was
important in your handwritten notes when you reviewed
the chart?

19

A. Well, that was the main

20

and object of the exercise as I understood it.

21

I may have missed things, of course.

22

Q. What I would like to point out

23

to you first, Doctor, is what I think you may have

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omitted in your notes.

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A. Yes.

4

Q. And get your comments on their
importance.

5

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Now this child spent most of her
time in the Hospital for Sick Children in the ICU?

7

A. Yes.

8

9

Q. But did transfer to the floor
some time before she died and she died on the ward?

10

A. Yes.

2

11

Q. Can you turn to page 73 and
74 of the Hospital record of this child?

12

13

A. Yes, I have got the page.

14

Q. Now at the bottom of that
page there is a note from Dr. Kobayashi who indicates
some of the problems that he is having or he is
noting with this child?

15

16

17

A. Yes.

18

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Q. And he then marks down his
impression which at that time the 7th of March
was digoxin toxicity. And on the next page there
is a further note from the same doctor saying that
his impression was or at least one of his impressions
was digoxin toxicity for this child.

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Now knowing what we know about the

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way you looked at these charts ---

A. Yes.

Q. - did you not feel that was an important enough fact to put into your notes?

A. Well, I didn't put it in and I can't tell you why I didn't at this stage. I have digoxin concentrations and I have a digoxin serum level for the 3rd of February, 17th, 24th and 7th of March which is I believe two days before the baby died.

Q. This is two days?

A. Yes. And the serum concentration of digoxin on the day that this note was written was 1.2 nanograms per millilitre.

Q. There is a note the doctor who wrote this note put into his note on page 73, last digoxin level which was on the 3rd - or the 2nd rather - 1.9.

A. Yes.

Q. Which was still within the therapeutic range.

A. Yes, sure.

Q. But he still puts down his impression or one of his impressions on page 73 and his only impression on page 74, digoxin



1
2 toxicity.

3 A. Well, that's all right, but
4 we have a serum digoxin level for that day, and
5 I would submit that that is very important information
6 that he would need to know because he would certainly
7 have to revise his opinion if he gets a serum
8 digoxin concentration of 1.2 nanograms on the day
he diagnoses digitalis intoxication.

9 Q. Well, isn't it possible with
10 the low reading that this child may exhibit symptoms
11 of digoxin intoxication?

12 A. Not in my book. Not with
13 nanograms of 1.2 per millilitre.

14 Q. What is your cut-off level?

15 A. For a baby? The therapeutic
16 range is 1 to 3 nanograms per millilitre.

17 Now I will go 3.5 or fourish. When
18 you start getting up at that level, yes, but not
19 at - I would say that is the therapeutic range.
20 And in fact all of these levels, 3rd of February,
21 7th of February, 24th of February, 7th of March
22 were all in the therapeutic range and that presumably
23 is the reason I didn't copy out his note.

24 Q. Doctor, would you turn to page
25 379.

A. Of the same chart?



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BB/PS

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Q. Of the same chart. On the bottom of that page on the next four pages there is a note from Dr. Contreras which seems to say, "ST changes? digoxin."

A. Yes.

Q. Now, you also didn't note that.

A. Well, why should I?

Q. Well, it seems that the residents who were looking after this child and were in day to day contact with her were questioning digoxin intoxication.

A. You can't diagnose digoxin intoxication from ST segment depression, it is one of the normal therapeutic effects of digoxin.

Q. Then do you have any explanation why a doctor would mark down "? digoxin".

A. Not at all, I can't read his mind. I am telling you something, you cannot diagnose digitalis intoxication from ST segment depression in the cardiogram. You don't even know if any specific degree of ST segment depression is in fact due to digitalis, even if the child is on digitalis, there may be other factors involved.

That isn't a toxic manifestation, an



1
2 electrocardiographic manifestation of digitalis
3 toxicity, not ST segment depression.

4 Q. What is an electrocardio-
5 graphic manifestation of digitalis intoxication?

6 A. Supraventricular
7 arrhythmias, excitatory arrhythmias, atrial
8 ventricular block, sinoatrial arrest, ventricular
9 ectopic beating ventricular tachycardia.
10 These are manifestations of toxicity, not ST
11 segment depression.

12 Q. So, did you ignore this
13 because it referred to the ST changes or because the
14 levels were still relatively therapeutic?

15 A. Yes, I was guided by the
16 relatively therapeutic levels, sure.

17 Q. Now, Doctor, notwithstanding
18 the levels, and I understand your position on the
19 level.

20 A. Yes.

21 Q. The doctors who were treating
22 this child were worried about digoxin and the non-
23 specific symptoms that we have heard all about.

24 A. Yes.

25 Q. Were also present in this
child.



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A. Yes.

Q. But that doesn't give you any cause for suspicion at all?

A. Well, you know, we are really going over the same ground I have gone over. I am trying to do my best to make a decision and, sure, they have got a suspicion and a very valid suspicion of digitalis intoxication but on the day they have that suspicion you get a value back within the normal therapeutic range for digoxin.

Now, I'm sorry, but if that happens to me in a clinical setting and I have considered digitalis intoxication, I surely, if I rely on my laboratory, and I feel that that is a proper estimation and if I don't, well then I had better do something about it, but I presume that's an accurate estimation, then I really feel I have ruled out digitalis intoxication unless this child had an extraordinary low potassium. If that is so, I missed it.

Q. Okay. Now, with regard to this child, this morning you told us this is one of the children in your review last night, that is, you couldn't sensibly conclude that this child died from a digoxin overdose.



1

2

A. Yes.

3

Q. But I note from your ---

4

THE COMMISSIONER: Was it sensibly?

5

I thought the question was rationally.

6

MR. LABOW: Rationally.

7

MS. CRONK: It was both, sir.

8

THE COMMISSIONER: It was both

9

rationally and sensibly. Well, I really meant
rationally better than sensibly.

10

MR. LABOW: I have both in there.

11

THE COMMISSIONER: But as long as

12

sensibly is in there, too, I am satisfied.

13

MR. LABOW: Q. Now, you had originally,

14

I take it from your index card, pegged this child
in the natural death.

15

A. Yes, I did.

16

Q. And changed it to low

17

suspicious.

18

A. At the 13th of September

19

meeting, yes.

20

Q. Can you tell me why, do you

21

recall why you changed it to low suspicious at that
time?

22

A. Well, for the same reasons

23

we have gone through already, there was a discussion,

24

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and I haven't read the minutes in detail again but
you can go over them.

Q. On Page 22.

A. 22.

Q. Page 22 of the minutes.

A. I think you will find some-
thing there that will indicate that there was
a change on my part.

Q. The only thing on Pages
22 and 23 are the exhumed tissue readings.

A. Yes.

Q. Which Mr. Cimbura says were
inconclusive. That was enough to make it somewhat
suspicious.

A. Well, again, you know I am
going through the same process. Here is Mr. Cimbura
coming up with some information, you know, can I let
it be natural, no, I change it to low suspicious.
Last night I went over this Category 5 as the
Commissioner had asked me to do and here we have
this child in congestive heart failure, coarctation
repair, post-operatively and congestive heart
failure, remained in chronic congestive heart
failure despite maximum digoxin and diuretic
therapy, suffered a cardiac arrest, and I felt that



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in order, you know, I felt after complying with the Commissioner's request that I would recategorize or categorize the child as no reasonable or rational or sensible basis for involving digitalis toxicity.

Q. Now, after this child's operations, this child was in the intensive care unit until the 26th of February and then was transferred back to the ward.

A. Yes.

Q. And he died ten days later. You previously commented in the minutes regarding Baby Belanger that one of the things you noted was Baby Belanger was well enough to leave ICU.

A. Yes.

Q. But that wasn't a comment that you attributed to Baby Gionas. Is that because there was a ten day span?

A. I don't think so, no. The baby was removed from the intensive care, I don't know what date that was. Do you have that date?

Q. I think it is February 26th.

A. February 26th and died...

Q. March 9th.

A. March 9th, which is about eleven days later. Well, clearly, the baby was removed



1
2 because there was nothing further that intensive
3 care or intensive nursing was expected to achieve
4 in the treatment of this baby, that whatever the
5 baby needed could be done on the floor. I mean,
6 that is, as you well know, a decision that is
7 being made all the day all over the province in
8 intensive care units. The baby may not in fact
9 have been all that well and presumably wasn't all
10 that well but wasn't expected to benefit at that
11 time from further stay in the intensive care. That
12 is the only thing I could think of.

12 MR. LABOW: Thank you, Doctor.

13 THE COMMISSIONER: Would this be
14 a convenient time?

15 MR. LABOW: Yes.

16 THE COMMISSIONER: Fifteen minutes,
17 then.

18 ---Short recess.

19 ---Upon resuming.

20 THE COMMISSIONER: Mr. Labow?

21 MR. LABOW: Thank you, Mr.
22 Commissioner.

23 Q. Doctor, next I would like to
24 look at the case of Paul Murphy. It is on Page 28 of
25 your report. It is the very large hospital record that



1

2

is sitting beside you.

3

Doctor, my only question about

4

Paul Murphy is ---

5

THE COMMISSIONER: I'm sorry, what
page did you say?

6

MR. LABOW: 28.

7

THE WITNESS: Yes, sir.

8

Q. I have previously questioned

9

some of the other doctors about an article, Dr.

10

Fowler's article on digitalis.

11

A. Yes.

12

Q. Which is Exhibit 174 at this

Commission.

13

A. Yes.

14

Q. And at Page 195 of that

15

article he refers to the central nervous system

16

effects and symptoms of digoxin intoxication. And

17

this child, or young man as the case may be, he

18

seemed to have exhibit many of those effects.

19

A. The CNS effects?

20

Q. Yes.

21

A. Yes.

22

Q. Including the nausea, the

23

confusional state, the severe irritability, which

24

was out of the ordinary for him, lethargy, and I was

25



FF

BB/PS

1
2 wondering if you didn't include those because they
3 didn't seem important or if you just didn't focus
4 upon them.

5 A. Well, I think I didn't
6 include them because I thought that there were more
7 reasonable explanations for those symptoms than
8 digitalis intoxication. It is true that the
9 CNS effect of digoxin is important. Certainly the
10 vomiting, now that pure digoxin is used, is
11 presumably likely to be an effect on the vomiting
12 centre rather than in old days when crude digitalis
13 was used, a tincture, where you've got a direct
14 irritation of the stomach. We believe now that
15 vomiting is a direct central nervous system
16 effect. Cases of delirium have been reported from
17 digitalis in adults, very, very uncommon. So, yes,
18 there certainly are. But when you come to those
19 symptoms here in this child I really didn't feel that
20 with the congenital heart disease that this child
21 had and the state the child was in that it was
22 anything other than a death due to his heart
23 disease, which was categorized as natural.

24 Q. Now, this child was actually
25 admitted at this time for a neurological evaluation.

A. Yes, I remember that now.



1

2

Q. But the nervous system problems

3

that digoxin might cause were not considered as part
of this neurological situation.

4

A. No.

5

6

Q. And my only question to you

7

is, should they have been and would it make a dif-
ference to you after I point these out to you. They
didn't seem to find any answers.

8

9

A. The child died -- when did

10

the child die?

11

Q. He died on August 23rd.

12

A. 1980. Well, I have a digoxin
level for four days prior to that in the therapeutic
range.

13

14

Q. Yes.

15

A. And the child was very sick

16

in other respects I would have said. I think it is

17

very difficult for me to suspect, and I would have

18

to look up the details of the neurologist's findings

19

and report that that lethargy and so forth if

20

that's what you refer to.

21

Q. Yes.

22

A. Is a result of digitalis

23

intoxication. I didn't think so and that's why I

24

put the category, C or natural causes as I did and

25



1
2 when I reviewed that last evening, and I had only
3 as you must realize my own notes that I had made
4 back in the summer of '82, I decided that this was
5 one that I could reasonably include under that
6 category which the Commissioner had mentioned to me
7 and, so, I did so. I didn't think the child did die
8 of digitalis intoxication.

9 Q. Now, in doing your re-review
10 for the Commissioner last night, isn't it possible that
11 had you reviewed the chart in depth you might have
12 found things that wouldn't make it as reasonable.

13 THE COMMISSIONER: The answer to that
14 has to be yes. You really should point out to him
15 what those things are that might change his view.

16 MR. LABOW: Well, in this case the
17 neurological problems that I think should be given
18 some weight in your consideration are found in the
19 hospital record, starting at Page 126 in the
20 progress notes and on August 19th ---

21 THE COMMISSIONER: I'm sorry, I
22 don't think it is 126. What day did you say here?

23 THE WITNESS: The diagram on Page
24 126.

25 THE COMMISSIONER: Oh, the diagram,
all right.



1

2

THE WITNESS: Is that it?

3

THE COMMISSIONER: Is that the page
with the diagram?

4

5

MR. LABOW: I'm sorry, no, Mr.
Commissioner, it is 124 on August 19th, there is a
comment about episodes of nausea.

6

7

On August 20th, which is on that
page, a neurology note, there are comments about
disorientation, not recognizing familiar surround-
ings and confusion on a persistent confusional
state.

10

11

12

THE COMMISSIONER: Is that a word,
confusional?

13

14

MR. LABOW: Yes, that is in the ---

15

16

THE COMMISSIONER: No, I was just
asking if it was a word. I thought confused was
the proper word.

17

18

MR. LABOW: Well, so did I, Mr.
Commissioner.

19

20

THE COMMISSIONER: Maybe confusional
is a word.

21

22

MR. LABOW: It is confusional in the
note.

23

24

25

THE WITNESS: I don't think the
neurologists like it, Mr. Commissioner.



13 1
2 MR. LABOW: Q. At Page 127 in the note
3 on August 21st, that's the second note on that page,
4 there is also confusion on awakening; on Page 129
5 in the first note, the very top note there is a
6 comment that he is aroused easily when he is
7 disturbed which, in this child, Doctor, is not
8 consistent with his normal way of acting. He is
9 apparently a very friendly, nice child and his father
10 comments later that he was surprised that his son
11 yelled at him.
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And as he continues vomiting on August the 22nd, and on August the 23rd at page 130, and in the middle of the page, in the second note:

"Confused and irritable many times throughout the day. Disoriented as to time and place times two. Dad states he has yelled out at me twice today and that is so unlike Paul."

Then August the 23rd, in the evening, he sits up in bed and then turns over essentially and dies.

A. Yes.

Q. Now, on page 133 is a neurologic consultation, but the neurological consultant is not terribly definite because the neurologist just isn't sure what all this is caused by, and those are the things that I am directing you to, Doctor.

A. Well, first of all the child is in congestive heart failure at the time that you are speaking of.

Q. Yes.

A. The child is sick.

Q. Unquestionably.

A. Very sick I would. I really



1
2 don't think that I could say that I thought it likely
3 that what you are reading to me is the result of
4 digitalis overdosage. I think the neurologists
5 suggest that they are thinking of it.

6 Q. No, they don't.

7 A. And I would say that these,
8 although they don't know the cause of his somnolence
9 or irritability, or alternating somnolence or
10 irritability and seizure activity which he had.
11 They don't know; the child was in severe congestive
12 heart failure. The only digoxin levels I have are
13 well within the therapeutic range, and I felt that
14 this child died of his heart disease and I categorized
15 him that there is no, to me, sensible conclusion.
16 I appreciate what you are telling me, but I really
17 can't fit it within digitalis toxicity.

18 Q. Now, would the heart failure
19 account for those kinds of symptoms?

20 A. Patients in terminal heart
21 failure can have odd neurological symptoms, yes, sir.

22 Q. Thank you. The next child I
23 would like to deal with is Matthew Lutes, and
24 Doctor, this is found at page 47 of your notes.

25 A. Thank you.

Q. Doctor, for this child,



1
2 notwithstanding that he had on the 14th of November
3 a digoxin level of 2.1?

4 A. Yes.

5 Q. Digoxin was held, and Dr. Rowe
6 at Volume 14, page 2437 said that the digoxin was
7 held because of the persistent vomiting, and although
8 the level was only 2.1 this may have been too high
9 for this child. On the 17th when he dies, he has
10 a severe bradycardic attack as the prime terminal
11 event.

12 Now, Dr. Rowe seems to indicate that
13 even though the level was in the therapeutic range,
14 and 2.1 is in your therapeutic range.

15 A. Yes.

16 Q. In this case they were concerned
17 about the digoxin, notwithstanding the low level.
18 Now, in your experience you would not consider that
19 pursuant to what you told me about Barbara Gionas,
20 the proper thing to do. You don't think that would
21 have any affect, it is 2.1, that is good enough, is
22 that your position? The level is 2.1, it can't be
23 digoxin.

24 THE COMMISSIONER: It can't be toxic.

25 MR. LABOW: Q. It can't be toxic.

A. Anything is possible in medicine,



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it is very unlikely.

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Q. Well, as unlikely as it was in this case specifically they thought that 2.1 might be toxic for this child.

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A. Well, we spoke of biological variability and I am prepared to go along with that if you want me to consider it. You have to make decisions you know on these things, you can't be stopping all afternoon on the ward chewing the fat over one lab study when you may be losing patients elsewhere.

12

13

14

15

Q. I understand that. I thought I took it from you when we discussed Barbara Gionas that you would never consider digoxin toxic at that level?

16

17

18

A. Well, if I - I don't know whether I said never, we can go back and find out if I said that.

19

20

21

Q. You didn't say never, but that was my impression of what you said.

22

23

24

25

A. Your impression was that I said never? Did I say never?

Q. No, you just said you wouldn't consider it toxic, period.

A. You know, here we have an



1
2 arrhythmia and the resident is writing out about this
3 and considers digitalis intoxication quite properly.
4 Then on the same day they get a level of 1.9, or 1.7,
5 1.9 nanograms per millilitre, well within the
6 therapeutic range. Now I think that with medicine
7 you are dealing with probabilities. If you were to
8 proceed on that basis and assume that that is digitalis
9 intoxication because this is say an exception, then
10 you might find yourself being hauled over the coals
11 at some mortality conference.

12 I would have to be guided by the
13 lab study, that is why we do them. That is why it
14 is so very helpful. 15 years ago we didn't have
15 that. So clearly we place some reliance on it. We
16 don't slavishly stick to it, after all it may be a
17 lab error, it may not have been 1.7, but I presume
18 the lab was correct, it probably was.

19 Q. Doctor, in this case they
20 reduce the digoxin?

21 A. Yes.

22 Q. That this child was receiving?

23 A. Yes.

24 Q. Even after a level of 2.1?

25 A. Yes.

Q. And apparently on the 16th of



1

2

November ---

3

A. Yes.

4

Q. --- they restarted digoxin

5

and the child died on the 17th, very early in the
6 morning?

6

7

A. Yes.

8

Q. After having a severe bradycardic
9 attack?

9

A. Yes.

10

Q. Is that something that you

11

should consider in these circumstances of your study?

12

A. Yes and I did consider it.

13

It was one of the cases that I reviewed at the
14 request of the Commissioner; and it was one of the
15 cases that I didn't put back into the category which
16 we have previously heard described.

16

Q. Yes.

17

A. Obviously I have some doubts
18 about that one.

18

19

Q. Thank you. The next child is

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Philip Turner.

21

A. Philip Turner?

22

Q. Philip Turner, yes, he is in

23

your 4 to 5 categories.

24

A. Yes.

25



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Q. And is at page 16 of your notes.

3

A. Yes.

4

Q. Now in this case the child was

5

once again in ICU?

6

A. Yes.

7

Q. Transferred from ICU on the

8

30th of July and died early in the morning on the
1st of August, just over a day later?

9

A. Yes.

10

Q. But that wasn't one of the

11

things that you referred to in your notes on page 17,
18 and 19.

12

13

A. The time relationship?

14

Q. The time relationship.

15

A. Yes.

16

Q. And I was wondering why?

17

A. Would you say that again?

18

Q. I was wondering why you didn't

refer to the time relationship?

19

A. Of transfer from the ICU and

20

dying?

21

Q. Because you had referred to it

22

in another case where there was also a one day gap.

23

You commented that if the child was well enough to

24

be transferred from ICU it raised your suspicion

25



1
2 somewhat.

3 A. Well, I suppose if it did on
4 that occasion, I was reviewing these charts on
5 different days and I can't give you chapter and verse
6 as to why I didn't comment on the time relationship.
7 Certainly the child had very severe congenital heart
8 disease.

9 Q. Now, you did comment I think
10 about the fact that a note was made that there were
11 episodes of sinus bradycardia and digoxin was not
12 always given, even though the latest level was only
13 .5, that is in your notes at page 18.

14 A. Yes, page 18?

15 Q. Page 18 of your notes:
16 "Episodes sinus bradycardia. Digoxin
17 not always given. Latest level 0.5."
18 That is taken right out of the progress notes?

19 A. Yes.

20 Q. And Dr. Izukawa's note where
21 he pointed out that the cardiac status appeared
22 controlled, that was his arrest note.

23 A. Yes.

24 Q. And you also referred to a
25 number of times with this child that digoxin was
held?



1

2

A. Yes.

3

4

Q. Digoxin was frequently held in
this child and Dr. Izukawa told us at Volume 59.

5

A. Yes.

6

7

8

Q. It was held because of
transient rhythm disturbances. Then just over a
day after the child is transferred back from ICU
the child dies?

9

A. Yes.

10

11

12

Q. With those facts in mind is
it possible that there is more than a low suspicion
in this case?

13

14

A. What is the date of the child's
death again?

15

Q. August the 1st.

16

17

18

19

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21

22

A. The day before the child's
death the digoxin was -- serum digoxin is 0.9
nanograms. This child had hypoplastic left heart
syndrome, a stenotic mitral valve with very small
left ventricle, stenosis aortic outflow, all of which
I know has been described to you by Dr. Rowe and
explained. These children die frequently very early
on in life, as I am sure Dr. Rowe has also explained.

23

THE COMMISSIONER: Dr. Rowe put this
child on the list of inevitable death, and by

24

25



1
2 inevitable death it doesn't mean the sort of inevitable
3 death that occurs to you and me, it is inevitable
4 death in the foreseeable future.

5 THE WITNESS: Yes.

6 THE COMMISSIONER: Would you agree
7 with that?

8 THE WITNESS: Yes, I would. That is
9 why I felt any suspicion had to be low and that is
10 why I put that down.

11 MR. LABOW: Q. And notwithstanding that
12 this child had a cardiac problem that Dr. Rowe said
13 is never, so far as I understand, had never been
corrected at the Hospital for Sick Children?

14 A. No.

15 Q. That is not my concern.

16 A. No.

17 Q. My concern is the last few
18 days of this child's life. Now, I put to you that
19 if they transferred him back from ICU they didn't
expect him to die a day later?

20 A. Well, you know, you have to
21 make a decision about ICU, what is the pressure for
22 admission to ICU. You are making judgments, and
23 you know, it is inevitable that you have to make
24 judgments as to who can leave this special unit to
25



1
2 make room for somebody with greater need. I know
3 that this is becoming more and more of a concern in
4 medicine and in your profession too. You know
5 although I mentioned on the one hand that you reminded
6 me that the baby was in good condition and died,
7 and this seems to be inconsistent to you. I really
8 in going over this to the best of my ability can't
9 put it in more than a suspicious category.

10 Q. Thank you. If we could quickly
11 look at Real Gosselin.

12 A. Real Gosselin, yes.

13 Q. Page 56 of your notes, Doctor.
14 Doctor, this child was not in the Hospital for
15 Sick Children very long. This is the child that
16 was transferred from Winnipeg.

17 A. Yes.

18 Q. After a high digitalizing dose.

19 A. Yes.

20 Q. They held digoxin on admission
21 and the level was 3.9.

22 A. Yes.

23 Q. And the child died the next
24 day.
25 -----



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Q. And the child died the next day.

Now you would put this into this category because of the note by Dr. Freedom?

A. Yes, I did. Well, that was one of the - I think that was a very major factor in my assessment.

Q. And Dr. Freedom has since explained to us that he didn't have those concerns but after he reviewed the chart he realized there hadn't been an adequate response to the prostaglandin treatment which was not his original view.

A. No.

Q. Now, Doctor, the symptoms the day before death, which is the only day this child was in the hospital.

A. Yes.

Q. Were increased lethargy, vomiting, arrhythmias and bradycardia, and you have noted and you have told us that there was a bradycardic incident?

A. Yes.

Q. And it was all repeated and then there was the arrest and the child died.

Now even without Dr. Freedom's comment,



HH2 1
2 knowing the relatively high level of digoxin at
3 this child's admission, would that in itself raise
4 a suspicion?

5 A. Yes, I suppose it would.

6 I understand that Dr. Freedom said
7 that because as I took it, and I was influenced
8 by Dr. Freedom's opinion, obviously I would be -
9 I really don't have any good explanation for this
10 baby's sudden deterioration and death, and I
11 understand that he was mistaken in applying that
12 to this particular child.

12 Q. That is correct. Well, he ---

13 A. Yes.

14 Q. He received information from
15 someone?

16 A. Yes.

17 Q. From one of the residents?

18 A. Yes.

19 Q. That this child had reacted
20 well to the prostaglandin treatment?

21 A. Yes.

22 Q. And then on review of the chart
23 felt the child had not reacted ---

24 A. Well, that certainly influenced
25 me and so when Dr. Freedom tells me that it certainly



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is taking away some weighting from my initial assessment, there is no question about that.

I gave it weighting on the basis of what he said, and if he said that was not correct, he was incorrect, he made a mistake, so now obviously I unweight my assessment to less than - I put down "possible" when I first ---

THE COMMISSIONER: At the moment it stands at a natural death.

MR. LABOW: Q. You have since decided that because Dr. Freedom's concern was no longer there ---

A. Yes.

Q. - you think this was also a natural death and would fall into a natural death. That is my understanding of your evidence since you have been here?

A. Yes, I am inclined - yes, I think that is true. I think that is what I said. It certainly made a big change in my assessment of the child.

The child as you point out did have a high digoxin level and had digoxin held. The child also had very serious heart disease which can lead to death in the first few days or weeks of life.



1 Again coarctation which is a preductal
2 coarctation, an abnormal mitral valve and this
3 hypoplastic heart situation again. But I couldn't
4 fail to change my opinion in view of the knowledge,
5 the information that Dr. Freedom was now satisfied
6 from his further enquiries that he could have
7 an adequate explanation for the baby's sudden
deterioration and death.

8 Q. So do I take it that if Dr.
9 Freedom has an adequate explanation you wouldn't
10 question that and you wouldn't ---

11 A. Well, I would still leave
12 that, you know, I think a little bit of a question
13 mark. But, you know, it is very, very difficult.
14 This baby has very severe heart disease and now
15 I am told something different from what I understood
16 when I reviewed the chart, which is a long time ago
17 now. So it has undoubtedly changed my initial
impression.

18 Q. Yes. Would you still
19 categorize this child then as a natural death?
20 Recategorize is probably a better word.

21 A. I think I would be inclined
22 to do that.

23 Q. So the high level and the
24 non-specific symptoms ---
25



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2

A. Yes.

3

Q. - wouldn't be enough to raise

4

any kind of suspicion.

5

A. Well, yes, it was high all

6

right.

7

Q. This child was admitted to

8

the hospital on the 17th?

9

A. Yes.

10

Q. According to the history at

11

2:30 in the morning, and died on the 18th, approxi-
mately one day later.

12

A. Well, Dr. Gordon Cumming in

13

Winnipeg was clearly very concerned about the

14

baby to transfer it all that distance to Toronto.

15

He thought that was the best thing to do clearly

16

and the baby was very sick.

17

I have said previously it is

18

difficult for me to know what weighting to give

19

the anatomic diagnosis, you know, in the context

20

of the situation I was in to do the review. But

21

I said that I was swayed very much by Dr. Freedom,

22

and when I heard that he changed his mind I had

23

to take that weighting off my assessment, and I

24

think I have to stay with that.

25

I had a slightly different approach to



1
2 Dr. Izukawa's testimony because it is a little different,
3 but I have to be - if I am swayed by Dr. Freedom
4 I have to be unswayed if he says that is not
5 what he meant.

6 Q. The last child is Kristin
7 Inwood.

8 Now, Doctor, that is page 92 of
9 your report. Doctor, when you did your initial
10 review --

11 A. Yes.

12 Q. - did you know that digoxin
13 was held on admission to the hospital because the
14 EKG showed signs of toxicity?

15 A. Well, I don't have it in my
16 notes here. I don't know why I didn't have it.

17 Q. Well, it was a little difficult
18 to find in the chart. And as well we found out that
19 the one dose of digoxin given to this child at
20 the hospital was a mistaken dose and there was
21 a patient incident report filed.

22 A. Yes.

23 Q. Do you recall knowing that
24 when you reviewed this, and I don't see a note of
25 that either.

26 A. No. The only notes I have



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2

about digoxin is an order for digoxin .006 BID
which is a maintenance daily dose, and a dig. level
on the day prior to death of 2.6 nanograms per
millilitre which is still I would say within the
therapeutic range.

6

7

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9

Q. Well, Doctor, would this
child, the dosage that you have down ordered for
the 11th was ordered held because of the EKG
result?

10

A. Was it, yes.

11

12

13

Q. And the dig. level that was
taken was taken because this child had mistakenly
received a dose of digoxin meant for another child.

14

15

A. Yes.

16

17

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19

Q. Then after that level was
taken or soon after this child died.

20

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Now one of the questions that I had
that I don't think you can answer is whether you
knew those two facts. I am asking you to try to
recollect that which I know is difficult.

A. Oh, you know, I can't - I
have a good memory, very good memory but I can't
recollect that 15, 16 months having gone through
49 charts on various days. I can't recollect that.
If I haven't got it in my notes I can't tell you.



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Q. Now, Doctor, this is the
child where we have the two votes taken?

4

A. Yes.

5

6

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Q. Now on page 6 of those notes,
that is the meeting, notes of the meeting, in the
second paragraph there is a comment that Dr.
Hastreiter is discussing the possibility of
contamination, and then it is noted that there was
a hold put on this child on March 12th.

10

A. Yes, yes.

11

12

13

Q. Is it possible that that was
one of the facts that may have helped changed your
mind on this child?

14

A. Oh, yes, I think quite
likely.

15

16

17

Q. Because that is not a fact
that I saw mentioned anywhere else in this typed
review nor is it mentioned in your note.

18

19

20

A. I think quite likely there
were certainly as you have seen before there was
discussion and there was change in assessments
so I would have to agree with you.

21

22

23

Q. Doctor, we have heard a lot
about the sample that led to the 491 nanogram
reading.

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A. Yes.

Q. Now even if this reading was a quarter of that or an eighth of that for a child that was not supposed to be receiving digoxin, and didn't receive any digoxin that we know of after the mistaken dose on the morning, the early morning of the 12th, would that indicate to you that this child received digoxin not meant for her?

A. Well, you said there was ---

Q. There was a mistaken dose 5:30 in the morning of the 12th.

A. Yes. That was after the hold had been put on?

Q. Yes. And then the hold --

THE COMMISSIONER: I'm sorry, I thought the hold came after the mistake.

MR. LABOW: No, on admission.

THE COMMISSIONER: Oh, I see.

MR. LABOW: Because the EKG showed signs of digoxin toxicity, digoxin was ordered held.

THE COMMISSIONER: Oh, I see.

MR. LABOW: Q. Then there was the mistaken dose at 5:30 in the morning and this child



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was pronounced dead at about 3 o'clock the following morning.

A. Yes.

Q. Now this child received a large maintenance dose - other people had testified that this dose was very large for this child.

A. Yes. I haven't got the child's weight down. It is a small, young baby, yes. Yes, it is high.

Q. My question: if that was the last dose given, if that child received the dose of digoxin at 5:30 in the morning?

A. Yes.

Q. By mistake.

A. Yes.

Q. And that was the last dose given.

A. Yes.

Q. And they then run an assay post mortem and they find a very high level that we can reduce to a tenth of that result, that would still be a result of 50?

A. Yes. You see you are getting me into an area where I really can't pose as having expertise. I am not an expert witness in pharmacokinetics.



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Q. Actually I am asking you for your clinical appraisal. If this was a child that you were responsible for and the child had not received a known dose of digoxin --

A. Yes, but the child --

Q. For 24 hours.

A. Well, no. I wouldn't - I would have expected some digoxin. I don't know how much but I wouldn't have expected the child to be free of digoxin in 24 hours.

Q. No, I wouldn't expect the child to be free from digoxin in 24 hours either.

A. So you are asking me to pass a comment on tissue concentrations which are beyond my area really. I don't know what they mean.

Q. No, I'm not asking you about the tissue concentrations.

A. What are you asking?

Q. I am asking what level you would expect the child to have a day later?

A. Serum level?

Q. In serum.

A. I have no idea what it would be. If the child had stopped receiving digitalis I would have thought it would be lower than 2.6 nanograms per millilitre which was the level I thought it was for the 12th.



II
BM/PS

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If it was held from the 11th and it was reported on the 12th at 2.6, are you asking me what level I would have expected on the 13th, the day of the child's death?

Q. Yes.

A. Well, I would have expected it to be lower, but how much lower I don't know. I have just been told here today there is some evidence in a publication that it can even rise. So, I would have expected it to be lower but how much lower I don't know.

Q. Now, your note on Page 93.

A. Yes.

Q. Where you have possible, question mark, not very likely?

A. Yes.

Q. Does that mean that there was a possible question or that you thought digoxin intoxication was questionably possible. I don't understand what your note means. The not very likely I understand.

A. Well, it is like some other bad habits, I suppose I put it in there and it marked off interrogation and I can't tell you what it means at this stage, really, at this



1
2 stage in relation to the possible not very likely.
3 Clearly, I am not putting it into the highly
4 suspicious probable category, we can all agree
5 on that, I presume. I am putting it rather low.
6 So, I can't say more than that. All these
7 categorizations, you know, are a little fluffy
8 for the most part, there is a little overlap, I
suppose.

9 Q. Now, after the September
10 meeting.

11 A. Yes.

12 Q. You re-categorized this
13 child to B plus, probable.

14 A. Yes, yes, I did, yes.

15 Q. And the note regarding the
16 lasix, in quotation marks.

17 A. Yes.

18 Q. You commented that that
19 dose of lasix might cause an electrolyte imbalance.

20 A. Well, it sounds like a very
21 reasonable dose of lasix, furosemide, it is any
22 of these powerful looped diuretics given intra-
23 venously can certainly cause fluxes of ions
24 of potassium and so forth which could have an
25 effect on the action of digitalis on the heart. But,



1
2 you know, I think I put that in parenthesis because,
3 as being stated before today, I was perhaps wondering,
4 I think I must have been wondering if that really was
5 lasix that the child received.

6 Q. Well, Doctor, if it was lasix
7 that the child had received.

8 A. Yes.

9 Q. And the level on the 12th is
10 2.6.

11 A. Yes.

12 Q. If there had been no other
13 digoxin given and we don't know of any, could that
14 have killed this child?

15 A. If that was lasix?

16 Q. Yes.

17 THE COMMISSIONER: We've been through
18 that with one child. Was it this child that we went
19 through the dosage?

20 MS. CRONK: Yes, it was.

21 THE COMMISSIONER: I think this one
22 we have been through before and I think the answer
23 was no.

24 MR. LABOW: Well, I didn't think the
25 answer was especially clear.

THE COMMISSIONER: Well, perhaps I'm



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wrong.

MR. LABOW: That is the only reason
I am asking.

THE COMMISSIONER: I thought with the
help of Mr. Roland who was giving evidence without --
didn't he tell us the precise amount?

MR. ROLAND: I'm sorry?

MS. CRONK: Yes, sir.

THE COMMISSIONER: Isn't this the
same one?

MR. ROLAND: I'm sorry, I was not
entirely paying attention. Were you talking about
Inwood?

MS. CRONK: Yes.

THE COMMISSIONER: You have had a
rough day.

MS. CRONK: It was put to the witness
and his answer was no, he thought it unlikely that
it would cause the demise of the child.

THE COMMISSIONER: Yes.

THE WITNESS: If that were digoxin,
yes, because, you see, it was quite a small dose,
really.

MR. LABOW: Thank you, Doctor.

THE COMMISSIONER: Is that it, Mr. Labow?



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MR. LABOW: Yes.

3

THE COMMISSIONER: Thank you.

4

Ms. Cecchetto, knowing that ---

5

MS. CECCHETTO: I have no questions,
Mr. Commissioner.

6

7

THE COMMISSIONER: No, wait, before
you answer that question, you realize that Ms.

8

Cronk is pinch hitting for Mr. Tobias for a while.

9

MS. CECCHETTO: Yes.

10

11

THE COMMISSIONER: So, you can't
really say that but are you prepared to let her go
ahead with both sections?

12

13

MS. CECCHETTO: I have no further
questions in any event.

14

15

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THE COMMISSIONER: All right. Well,
there you are. Now you can go free without
anybody having any chance to answer you.

17

18

MS. CRONK: Except possibly Mr.
Tobias when he sees the questions.

19

THE COMMISSIONER: Yes, all right.

20

21

MS. CRONK: Doctor, I will try
to be brief. It has been a very long three days
for you and I know that.

22

RE-EXAMINATION BY MS. CRONK:

23

24

25

Q. Doctor, you have been asked



Fay, re. ex.
(Cronk)

1
2 to review your conclusions with respect to a number
3 of these children in some detail. You will recall,
4 Doctor, that yesterday Mr. Brown drew your attention
5 to the cases of Charlon Gardner, Matthew Lutes and
6 Francis Volk.

7 A. Yes.

8 Q. And to the fact that when it
9 came time to vote at the September 13, 1982 meeting
10 with respect to these children the medical expert
11 had a different opinion, he suggested, than did
12 the homicide squad and that in fact appeared to be
13 the case as recorded in the minutes.

14 A. Yes.

15 Q. Do you recall that discussion
16 yesterday?

17 A. Yes, yes, I do.

18 Q. And in each of those three
19 cases, Doctor, both Dr. Hastreiter and yourself
20 considered that death was due to natural causes.
21 Do you recall that as well?

22 A. Yes, I do, yes.

23 Q. In certain other cases,
24 Doctor, I am going to suggest to you that there was
25 total unanimity in categorizing the death as being
due to natural causes. Unanimous consensus was



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reached inclusive of the homicide team vote, that with the case, for example, as I understand it, with Alan Perreault. Does that accord with your recollection, Doctor?

THE COMMISSIONER: It would help if we had the papers.

MS. CRONK: It is in the minutes, Doctor.

THE COMMISSIONER: What page?

MS. CRONK: Q. Page 27, Doctor.

A. Page 27?

Q. Page 27.

A. Yes, yes, I have it, Alan Perreault.

Q. There were a number of these, Doctor. Perhaps we can just move through them rather quickly.

A. Yes, yes.

Q. With Alan Perreault there seems to have been complete unanimity amongst all those present at the meeting.

A. Yes.

Q. The same appears to have been true with David Leith, if we flip to the next page, Page 28.



1

2

A. Yes.

3

Q. The same appears to have been

4

true with Laurette Heyworth, that vote is contained

5

at Page 19 of the minutes.

6

A. Yes.

7

Q. Do you see that, Doctor?

8

A. Yes.

9

Q. Laurette Heyworth?

10

A. Yes.

11

Q. The same appears to have been

true with Paul Murphy, the child you spoke about a

12

few moments ago.

13

A. Yes.

14

Q. That vote is at Page 20.

15

A. Yes.

16

Q. Again complete unanimity.

17

A. Yes.

18

Q. And the same is true with

Bruce Floryn, and the vote is on the same page, Page

19

20.

20

A. Yes.

21

Q. All right. In all of those

22

cases, Doctor, as I have suggested to you, there

23

appears to have been no dissension among the group,

24

nor any dissenting opinion with respect to the manner

25



1
2 in which the death was categorized. If we come to
3 the conclusion of the meeting on September 13th we
4 find at Page 28 of the minutes that there was a
5 further discussion as to the appropriateness of
6 the various categories which had been suggested
7 at the outset of the meeting. This is the very last
8 page of the minutes, Doctor, Page 28.

8 A. Oh, Page 28, yes, yes.

9 Q. And we see, Doctor, in the
10 case of the category of natural deaths, the
11 definition at the conclusion of the meeting was
12 that those deaths to which a natural death was
13 attributed would be those where the cause of death
14 had been thought to be clearly defined and the likeli-
15 hood of murder had been excluded. Am I correct,
16 Doctor?

16 A. Yes.

17 Q. All right. Did you have any
18 difficulty with that definition, as best as you can
19 recall it, at the end of the meeting?

19 A. No, no.

20 Q. So, in those cases at least,
21 Doctor, all of which I should tell you, and you may
22 recall this yourself, are included in the group
23 that you outlined to the Commissioner today, at least
24
25



1
2 in those cases there doesn't appear to have been
3 any question either from the medical contingent,
4 if you will, present at the meeting.

5 A. Yes.

6 Q. Nor from the pure investigatory
7 side of those present at the meeting with respect
8 to why those particular children had died?

9 A. That is correct.

10 Q. All right. Doctor, in the
11 case of Antonio Adamo, for example, this is at Page
12 15 of the minutes, it appears that the homicide
13 team in that case had concluded that the child's
14 death was attributable to natural causes while
15 the medical experts had voted for low suspicious.
16 Do you see that, Doctor, at Page 15, Antonio
17 Adamo?

18 A. Yes, yes, that's right,
19 yes.

20 Q. And then, Doctor, we come to
21 the case of Kristin Inwood about which much has been
22 said and in that case it has been pointed out, that
23 is the only case as has been pointed out, where a
24 second vote was taken by those who were present
25 at the meeting. This child, as I read the minutes,



Fay, re. ex.
(Cronk)

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Doctor, is the second child whose case was discussed in detail at the meeting on September 13th, is that correct?

A. Yes. I think you have them here in the order in which they were discussed.

Q. That makes Jordon Hines the first.

A. Yes.

Q. And Kristin Inwood the second?

A. Yes.

Q. And you have told us, I believe, if I am recalling it correctly, Doctor, that that meeting started first thing in the morning and lasted well after lunch into the afternoon.

A. It certainly started early in the morning, fairly early in the morning and it lasted longer than I had recalled, it lasted until 5:10.

Q. I presume, then, Doctor, that at the time this case was being discussed it was early during the morning after the meeting had started.

A. Yes.

Q. And the second vote in the



1
2 case I suggest to you, Doctor, was taken only after
3 Sergeant Press and Mr. Wiley had commented as is set
4 out on Page 6 of the minutes, on what they felt
5 should be the direction or the focus of the meeting,
6 isn't that correct?

7 A. Yes, that is correct.

8 Q. And that was at a time, I
9 suggest, Doctor, because that is the timing of the
10 second vote, when the parameters of the meeting
11 may well have been set.

12 A. I think you are probably right.

13 Q. All right. Doctor, when the
14 first vote was taken, if we can turn back to see
15 what was happening at the meeting at that stage,
16 the result of that vote is set out at Page 5 and
17 it is apparent, I suggest to you, Doctor, from
18 the minutes, that all of those present, all of the
19 medical experts, all of the individuals who were
20 participating in the vote had some measure of
21 suspicion with respect to the cause of this death,
22 even on the first vote, isn't that correct, Doctor?

23 A. Yes, that is correct.

24 Q. Indeed, of the physicians
25 present, all of them regarded it as suspicious,
inclusive of yourself, save that you placed it on a



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slightly lower down scale, you placed it in the
category of low suspicious.

3

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A. Yes.

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Q. All right. Doctor, you recall
as well yesterday your attention being drawn, as I
am sure you do, to the case of Jordan Hines by Mr.
Strathy.

8

A. Yes, I do.

9

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Q. I direct you to Page 3 of
the minutes. This passage was brought to your
attention by Mr. Strathy, as indeed it was by me
during your examination-in-chief. He was referring
to one of the comments made by Dr. Hastreiter and it
is recorded in the minutes in the last paragraph
on Page 3 in which it says:

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"Playing the role of devil's
advocate, he stated the argument
for SIDS is very good. The baby may
have had missed-SIDS earlier with
spells where stopped breathing."
Do you recall that passage being brought to your
attention?

21

22

A. Yes, yes, I do recall that
passage being brought to my attention, yes.

23

24

25

Q. And that comment, as the



1
2 minutes suggest, appears to have been made by Dr.
3 Hastreiter in the role of a devil's advocate, if
4 you will.

5 A. He did just that, I clearly
6 remember that part of the meeting very well.

7 Q. All right. Would it be fair
8 of us to conclude, Doctor, that he was advancing the
9 SIDS argument as a potential cause of death of this
10 child for the purposes of canvassing both possibilities
11 that were then before the meeting?

12 A. Oh, I think so, because I
13 engaged in some discussion with him which isn't all
14 recorded here and he was stressing the anatomic
15 findings in Sudden Infant Death Syndrome.

16 Q. All right. Doctor, if you
17 would turn back to the previous page, if you would.
18 Dr. Hastreiter made some other remarks concerning
19 this child's cause of death in SIDS which were not
20 drawn to your attention yesterday.

21 At Page 220 at the bottom of the
22 page, he said:

23 "Another diagnosis was the
24 possibility of Sudden Infant Death
25 Syndrome. The autopsy revealed the
baby had some of the findings of



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Do you see that, Doctor?

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A. Yes, I do.

8

Q. All right. And that was

9

Dr. Hastreiter's apparent first comments with

10

respect to this child.

11

A. Yes.

12

Q. All right. And then, Doctor,

if we turn over to Page 3.

13

A. Yes.

14

Q. The very last comment in the

15

meeting Dr. Hastreiter is recorded as saying:

16

"He said the great difficulty would

17

be to explain the digoxin levels.

18

Dr. Hastreiter said there are three

19

disturbing features in this death:

20

(1) Unexpected death;

21

(2) Sequence of arrhythmias;

22

(3) High levels of at least fully
therapeutic digoxin and very

23

suggestively higher than therapeutic

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level in the liver."

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Specifically, and we will hear in
due course, Dr. Fay, from Dr. Hastreiter, it appears
that he felt this child's death to be unexpected,
isn't that correct?

6

A. Yes, he did, he did.

7

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Q. And as well, Doctor, was he
not, as appears from the minutes, concerned with the
mode of dying in this case, the sequence of arrhythmias
that he had noted?

11

A. Yes, that's right, yes.

12

Q. Were you concerned as well,
Doctor, by the mode of death in this case?

13

14

15

A. Yes, that was really one of
the things I had to go on, the arrhythmias and then
the toxicology, of course.

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Q. All right. Doctor, if we turn
to the next page, just before we come to the vote on
Jordan Hines we see another comment recorded by
Dr. Hastreiter, he said:

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"Dr. Hastreiter said the other thing
about SIDS is that the child was being
monitored, which is exactly how one
prevents SIDS."

23

Do you see that, Doctor?

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A. Yes.

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Q. At the top of Page 4.

4

A. Yes.

5

Q. In fact, Doctor, the evidence

6

before the Commission in this case has established

7

that at the time of his death Jordan Hines was on

8

two monitors, both an apnea monitor and a cardiac

monitor.

9

A. Yes.

10

Q. Do you recall that from your

11

review of this child's records, or at least the fact

12

that he was under monitoring at the time of his

death?

13

A. Yes, I knew the child was

14

being monitored, yes.

15

Q. Would you agree with me,

16

Doctor, that the purpose in a hospital setting of

17

intensive monitoring is to alert the attending

18

medical staff quickly to changes in the child's

medical condition?

19

A. Oh, yes.

20

Q. All right. It is really a

21

form of early detection device, isn't it, Doctor,

22

as well as being an aid in the treatment of any

23

particular child?

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A. Of course, yes.

3

Q. All right. Would you agree with

4

me as well, Doctor, that most deaths attributed to
Sudden Infant Death Syndrome occur in the home as
opposed to a hospital setting?

5

6

A. Yes.

7

Q. All right. Having regard

8

to those comments by Dr. Hastreiter recorded in the
minutes that I have just drawn to your attention,
was there any doubt in your mind at that meeting,
Doctor, what he regarded to be the likely cause of
death in that case?

9

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11

12

A. Not when we finalized the
discussion, no.

13

14

Q. All right, thank you, Doctor.

15

And you yourself at the conclusion of the meeting
voted it to be in the probable category, did you
not?

16

17

A. Yes, I did.

18

19

Q. All right. You told me

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yesterday in the context of Jordan Hines, Doctor,
and this is really a point raised by one of the

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22

absentee counsel today, but you told me yesterday
that in your experience arrhythmias could accompany
or be seen in deaths which were ultimately ascribed

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19 1
2 to Sudden Infant Death Syndrome.

3 Do you recall saying that?

4 A. Yes, I did say that, yes.

5 Q. Doctor, I take it we would
6 have no disagreement at all if I confirmed or suggested
7 to you that you confirm again for us that you are
8 not an expert with respect to Sudden Infant
9 Death Syndrome?

10 A. Oh, no, no, no, not at all.

11 Q. Doctor, are you familiar with
12 the literature on the pathological indicators of
13 Sudden Infant Death Syndrome?

14 A. Oh, I know, yes, I am aware
15 of the pathological indicators; some of them,
16 anyway.

17 Q. All right. Doctor, if the
18 literature suggested, the literature in that area
19 suggested that arrhythmias, although possible, were
20 an unusual feature to accompany a Sudden Infant
21 Death Syndrome, would you have any basis to quarrel
22 with that?
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J/DM/ak

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A. Not at all, not at all.

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Q. It is impossible, Doctor, I'm not suggesting it can't happen, but the literature I suggest seems to indicate that it is most unusual, would you agree with that?

7

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A. Yes, I have a review of Pediatrics 1983 on Sudden Infant Death Syndrome and I don't think it is stressing chronic arrhythmias, you know.

10

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Q. And, Doctor, similarly, if the literature in this area suggested that it was unusual for a neonate, a child under 30 days of age to have death attributed to Sudden Infant Death Syndrome, I assume you wouldn't quarrel with that either?

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Q. Doctor, with respect to the ranking generally in a number of these deaths which you have explained in great detail and in considerable patience what was in your mind at the time you categorize these deaths. You have told us this morning that having thought about the matter further your best recollection is that you completed your index card ratings before attending that meeting of September 13th; do I understand that correctly?

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A. Yes, I think that is correct.



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Q. And I take it then, Doctor, that - well, it is also my understanding from what you said this morning that as best you can now recall it you did before the meeting of September 13th have on hand at least some of the toxicology data from the Centre of Forensic Sciences.

A. Oh, I certainly did, yes.

Q. And you have told us ---

A. I probably had the majority, I don't know, I think I probably had the majority, I don't know. There were certain areas that I am sure were brought out then that I didn't have before. I think I had the majority, but as I have said before I never at any time had given to me a complete file on all the children and the digitalis levels and so on, the digoxin levels and so on, I never had that sort of thing.

Q. You never saw a formal report in any way from the Centre?

A. No.

Q. But your best recollection is that you did have I think you said most of that data?

A. I think I had most of it before I went to that meeting.

Q. Can we look then, Doctor, just



1
2 for the moment at the ratings which you did ascribe
3 to these children before the September 13th meeting.
4 Starting with the case of Justin Cook; your index
5 card in that situation indicates you categorize this
6 death as an A+, and that is before you went to the
7 September 13th meeting, is that correct?

8 A. Yes.

9 Q. And your final conclusion when
10 you left the September 13th meeting was to leave it
11 as well in the probable category; am I correct in
12 that, this is just in Cook?

13 A. Yes.

14 Q. We come, Doctor, next to the
15 case of Allana Miller, and once again your index
16 card rating for this child which you made personally
17 before you went into the September 13th meeting was
18 to place her in probable category.

19 A. Yes.

20 Q. I'm sorry, Doctor, the reporter
21 can't hear that.

22 A. Yes.

23 Q. And your final conclusion at
24 the end of that meeting was to leave her in the same
25 category the highly suspicious category?

A. Yes.



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Q. And then we turn to Kevin Pacsai, Doctor, the third in your group of eight, and before you went into the September 13th meeting your rating then, on the basis of what you then had, was an A+ for that child, that is Kevin Pacsai?

A. Yes, could you just give me the pages, I would just like to flip - I am sorry, I should know them by heart by now.

Q. That is all right.

A. No, no, I would just like to flip through them.

Q. Kevin Pacsai, Doctor, your index card indicates page 31, I am talking now about your index card.

A. Yes, I realize that.

Q. Page 31.

A. Yes.

Q. I don't think you have them in that book?

A. No. The index cards?

Q. Yes.

A. I have a Xerox of the index card here.

Q. You do?

A. Yes. The patient is on page



1

2

what of my notes?

3

Q. Page 87.

4

A. Thank you.

5

Q. What I am suggesting to you,

6

Doctor --

7

A. Okay, yes, all right, I am with

8

you, yes.

9

Q. That your rating of that case,

10

that is the cause of death before you went into the
meeting.

11

A. Yes.

12

Q. Was A+?

13

A. Yes.

14

Q. According to your index card,

15

and when you came out of the meeting it was the same,
still in the high probability category?

16

A. Yes, it was.

17

Q. And then we come to the case

18

of Janice Estrella, and your index card rating with

19

respect to that child again before you go into the

20

meeting is an A, in the highest category, and when

21

you come out of the meeting and do your case review

22

I suggest to you it is the same, you indicate that

23

digoxin you felt to be, it was probably an over-

24

dose of digoxin had applied in that case?

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A. Yes.

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Q. You have told us that those

4

four children were not discussed in detail at the

5

September 13th meeting. We come then to the case

6

of Stephanie Lombardo.

7

A. Yes.

8

Q. That case was discussed in some

detail at the meeting.

9

A. Yes.

10

Q. Now your index card in that

11

case before going into the meeting shows a B+,

12

probable, is that correct, Doctor?

13

A. Yes.

14

Q. And you come out of the

meeting and your conclusion I suggest to you is

15

effectively the same?

16

A. Yes.

17

Q. You indicate that in your opinion

18

digoxin was the immediate cause of death?

19

A. Yes.

20

Q. And then we come to Jesse

Belanger, once again your rating before you go into

21

the meeting is a B+?

22

A. Yes.

23

Q. And you come out of the meeting

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and prepare ultimately your final conclusion and I suggest once again it is effectively the same, you indicate that in your opinion digoxin contributed to the death of the child?

A. Yes.

Q. Then we come to Kristin Inwood, Doctor, and much has been said about that in the last three days. It is clear that in that case when you went into the meeting you had first graded the child with a B, the suspicious category, that is on your index card?

A. Yes.

Q. Then you changed it to a B+ or the probable category on your index card?

A. Yes.

Q. And I take from that that it was ultimately the complete discussion at the meeting that you changed your rating upwards from a B to a B+?

A. Yes. My change was as a result of the discussion at that meeting, yes.

Q. And finally in the group of 8, Doctor, we come to the case of Jordan Hines. I suggest that on my reading of the index card your personal judgment on the matter before you went to



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the meeting on September 13th was that that case as well had to be put in at least a B or possible category?

A. Yes.

Q. And when you came out of the meeting you felt still that it was a good possibility, except you changed the letter that time to read an A, do I have that correctly, this is Jordan Hines?

A. Yes, I think that is correct.

Q. With the exception then of Kristin Inwood, Doctor, would it be fair to suggest to you that your index card ratings of these children, that is the judgments that you had reached on all of those eight children before you attended the meeting of September 13th, remained essentially the same before and after the meeting at which the cases were discussed in some detail?

A. With the exception of Inwood.

Q. Is that right, Doctor?

A. Yes.

Q. Doctor, you told Mr. Roland this morning, as I understood it, that in assessing these cases you relied, as it is apparent that you did, on the toxicological data provided by Mr. Cimbura.

A. Oh, yes.

Q. Is that correct?



Fay, re-dr.
(Cronk)

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A. Yes, very much so.

3

Q. And as I understood Mr. Roland

4

he suggested to you, and I think you agreed, that

5

in most of these cases there was nothing in the

6

chart itself to suggest digoxin intoxication, did

7

I understand you correctly?

8

A. Well, really not, specifics

9

we were talking about, that is true.

10

Q. Doctor, I would like to look

at some of these collectively for a moment if I may.

11

A. Yes.

12

Q. Some of these cases, Doctor,

13

as I read your notes and your case reviews, there was

14

no toxicology available to you, yet you concluded that

15

there was a basis to be suspicious, isn't that correct?

16

A. Yes.

17

Q. That was the case for example

with David Taylor, we have heard your evidence

18

concerning the significance attached to Dr. Izukawa's

19

note.

20

A. Yes.

21

Q. Leaving aside the case of

22

David Taylor; wasn't that also the case of Lillian

23

Hoos?

24

A. Yes.

25



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Q. No toxicological data available to you but you felt having reviewed the chart that there was reason to be suspicious?

A. Yes, I did.

Q. Wasn't that also the case with John Onofre?

A. Yes.

Q. And to be fair to you, Doctor, in that case, the minutes indicate that Mr. Cimbura disclosed at the meeting that there was no toxicology data available and this Commission knows that in fact toxicology tests were done for digoxin but the results were not available until December of 1982.

A. Yes.

Q. I take it, or I should ask you if you, after the meeting of September 13th, after dictating your case reviews were ever provided with the results of those further tests on that child?

A. Never had any further information at all.

Q. I thought not. So as it stood then at September 13th, both before the meeting and at the meeting you did not have the benefit of any toxicology data, yet you felt there was reason to be suspicious as to that child's death and the



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involvement of digoxin?

A. Yes.

Q. And similarly was that not
also the case with Philip Turner?

A. Yes.

Q. Wasn't that also the case with
John Onofre?

A. Yes.

Q. Wasn't that also the case with
Richard McKeil?

A. Yes.

Q. No toxicology?

A. Yes.

Q. Wasn't that also the case with
Antonio Adamo, no toxicology?

A. Yes.

Q. None of those cases then,
Doctor, was the toxicological data with respect to
digoxin concentrations available to you?

A. Yes.

Q. Which you could look to to
form an opinion that there was a possibility that
digoxin was involved in their deaths?

A. That is right.

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Q. I take it then, Doctor,

on the basis of what you read in the medical charts,
and the information that was in that form available
to you that you felt that you could not rule out the
possibility of digoxin intoxication as the cause
of death?

A. Yes. As I say, information
available to me, remembering the context in which
I was looking at these cases.

Q. Doctor, you specifically
confirmed, as I understand it, that in some cases
the very mode of death was enough to make you
suspicious, you told me that yesterday, as I understand
it, about Amber Dawson.

A. Yes.

Q. You told me that about
Lillian Hoos?

A. Yes.

Q. And isn't that also the case
about Jordan Hines?

A. Yes.

Q. Doctor, dealing with Kristin
Inwood again for a moment from a different perspective,
you told Mr. Strathy this morning as I understood it
that digoxin could well have been confused for lasix



1
2 having regard to the notes that were contained in
3 the progress notes in the last hours of that child's
4 life; do you recall that discussion?

5 A. Well, I said -- yes, there is
6 a possibility, I thought there was a possibility.

7 Q. I'm sorry, Doctor, right.

8 A. That is all I said. I
9 didn't think I put it as strongly as "could well
10 have," I don't know. I thought there was a
11 possibility. That is why I wrote it the way I did.

12 Q. Doctor, as I recall the dis-
13 cussion this morning you started to describe the forms
14 in which lasix, the forms with which you were
15 familiar in which lasix is provided, to Mr. Strathy,
16 but I don't believe you finished. Are you aware
17 of the colour of the vials or ampules in which lasix
18 is generally provided?

19 A. They are dark brown.

20 Q. Brown?

21 A. Yes.

22 Q. Are you familiar with the
23 colour of the ampules in which digoxin is normally
24 provided?

25 A. They are clear ampules with
green printing.



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Q. Is there a difference in the printing on the vials between the lasix and the digoxin, be it pediatric or adult ampule?

A. Well, we checked that, there is only the adult ampule, there is only the one ampule.

Q. Of lasix?

A. Of furosemide, yes, lasix, yes.

Q. Is there a difference between the printing on these and the printing on the digoxin ampules with which you are familiar?

A. Well, the printing on the furosemide ampule is in white printing, the printing on the digoxin ampule is in green.

Q. Doctor, I accept fully that medication errors even in the most sophisticated and expert of hospitals do in fact occur.

A. Yes.

Q. Would you agree with me, however, Doctor, that the likelihood of mistaking one drug for another is reduced if the colour of the containers in which the drugs are provided is different and the labelling on the containers is different, there is a reduction in the possibility



1
2 of a medication error taking place; would you
3 agree with that, Doctor?

4 A. Yes.

5 Q. Doctor, you will recall there
6 was discussion as well concerning the case of
7 Antonio Velasquez this morning.

8 A. Yes.

9 Q. I don't think you will need
10 the medical chart for this, but if you do, please
11 feel free to ask for it.

12 Your attention was drawn to Page 29
13 of the medical record, that is the page that sets out
14 the terminal events suffered by the child leading
15 to the actual arrest. In the course of your
16 discussion with other counsel this morning, you
17 indicated that in your view certain of the terminal
18 events that he suffered would not be regarded by
19 you as manifestations of digoxin intoxication. You
20 referred to the somnulence that he suffered; the
21 pinpoint pupils and the hypothermia, do you recall
22 that?

23 A. Yes, I do.

24 Q. Doctor, amongst the terminal
25 events that are described on Page 29 of the medical
record, and I ask you to accept this from me but if



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you would like to see the medical record --

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A. No, I will accept it.

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Q. It is recorded also the

following: Bradyarrhythmias, then tachyarrhythmias

progressing to asystole, irregularity on the ECG,

bradycardia. I take it from what you have been saying,

Doctor, over the last three days that we can

agree that those features are in your judgment manifesta-
tions of digoxin toxicity?

A. Well, I keep saying that they

are seen in digitalis toxicity. I said late this

morning they are also seen in other situations.

They are not diagnostic of digitalis toxicity.

Q. I understand that, Doctor.

They are, however, consistent with digoxin
intoxication?

A. Yes.

Q. Doctor, with respect to the,

and maybe I am mispronouncing this, I have had

historically difficulty with the word somnolence

that the child was experiencing.

A. It is perfectly pronounced.

Q. Am I correct, Doctor, that

drowsiness and difficulty to arouse is an often



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seen adverse reaction to Codeine in an infant?

A. Yes.

Q. And dealing now again--this again arose in the context of your discussion of a number of children, and specifically Velasquez as well, that is the subject of convulsions, the frequency with which we see in these cases seizure like activity. Your attention was drawn to the evidence of Dr. Bain and it was suggested to you that he had said that in 16 of these cases he had noted convulsion like activity, if you will.

Fairly, Doctor, I think you should be told that Dr. Bain said, and this is found, Mr. Commissioner, at Volume 62 in response to a question put by Mr. Labow:

"Now, there are --"

I'm sorry, Dr. Bain outlined the names of the children in whom he noted convulsions or seizure like activity.

A. Yes.

Q. He then said:

"Now, there are varying things in those, Mr. Labow, and this is why I feel a little uncomfortable about them without going back and



1
2 having somebody else check them too,
3 is whether it was a real convulsion
4 or some sort of convulsive activity,
5 you know, a minor thing where the face
6 started to twitch or something like
7 that and quickly went away. Or as
8 in Velasquez, you remember where he
9 arched his back and we talked about
10 that. I am not sure it can be a
11 convulsion. Some people think of a
12 convulsion as going on to the real
13 shaking stage of it, and I am not
14 referring to that. I am referring
15 to the early part of convulsive
16 activity, any phase of it."

15 It is clear, I suggest, Doctor,
16 from what Dr. Bain said that he was speaking of a
17 broad range of physical manifestations which might
18 broadly be described as coming under the umbrella
19 of convulsions.

20 A. Yes.

21 Q. In your mind, Doctor, with
22 the discussions that you heard as to the frequency
23 of convulsions in children suffering from
24 digoxin intoxication, were you placing on that word
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(Cronk)

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a more restrictive meaning, or the same kind of
meaning as Dr. Bain, or indeed did you lend your
mind to it?



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A. Oh, of course I have lent my mind to it. I have been lending my mind to it vigorously for the last three days.

You see going back to that paper of Dr. Fowler's, that is one case of seizure - I don't know what sort of seizure it was - in 30 patients or whatever.

Q. Can I stop you there for a moment?

A. Yes.

Q. I am going to help you with Dr. Fowler's paper and direct your attention to it. But just for a moment when you think of convulsion-like activity in a child where a suggestion is made that the child was suffering from digoxin intoxication, in the conversation that you had did you have a particular kind of convulsion in mind.

That is really my only question. If you didn't, that is fine, and if you did I would like to understand what it was.

A. A convulsion to me means more than a twitching of the lips.

Q. All right. What kind of activity were you contemplating?



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2 A. Well, you described one phase
3 of it, the opishotonos that Dr. Bain referred to.
4 I take it he took that as equivalent to seizure
5 without the jerking without the clonic phase
6 of movement or if there were jerking, involuntary
7 movements of a limb or one side of the body,
8 yes, that is a seizure, if you like, which comes.

9 That is what I would take as a
10 seizure, not just a twitch of the eyelid or of the
11 mouth. I don't call that a seizure.

12 And furthermore I have also stated
13 that I don't think from my knowledge at the present
14 time, and going on Dr. Fowler's paper from what
15 I have heard of that, that seizure activity ranks
16 high as an indicator or as a symptom suggestive
17 of digitalis intoxication.

18 If that is the case I am certainly
19 going to read all about it because it is most
20 fascinating and I can present it at grand rounds
21 the next time I am called upon to present.

22 Q. Well I am certainly not
23 disagreeing with you on that, Doctor, but I would
24 like to draw your attention to certain aspects
25 of Dr. Fowler's study which have not yet been
brought to your attention.



1
2 Indeed if I have a moment before
3 you leave for your train back to Kingston --

4 A. I am not catching the train.

5 Q. I will see that you get it.

6 With respect to Dr. Fowler's study
7 he found (this is Exhibit 174, Mr. Commissioner)
8 he found convulsions as you have been told.

9 A. Yes.

10 Q. In 3 per cent of the cases
11 his study group reviewed, and he also found --

12 A. That is one of 30 cases,
13 isn't it?

14 Q. 31.

15 A. Well, we will still have to
16 leave it at 3 per cent.

17 Q. That is right. 3 per cent.

18 And he also found that in the
19 reported cases in the literature that were available
20 to his study group it had been noted in digoxin
21 intoxication in 6 per cent of the cases.

22 I tell you, Doctor, however, that
23 in all of those cases reviewed by Dr. Fowler with
24 the exception of 2, all the patients had normal
25 hearts.

 My question to you is, Doctor, can
we agree that the frequency of seizure-like activity



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2 in cases of digitalis intoxication involving
3 children with very serious heart disease may in
4 fact be an unresolved issue in the medical community
5 at the present time? I am suggesting to you we
6 are talking about children with very serious heart
7 disease.

8 Are you aware of any article or
9 any matter in the literature which speaks to the
10 frequency with which seizure like activity might
11 be expected to be manifested?

12 A. Well, you know, just up the
13 road we have got an institution that is getting,
14 I don't know how many cases a year of children
15 with serious heart disease. Many of them are put
16 on digitalis, and dig. levels are taken and dig.
17 toxicity is looked for.

18 If this were a frequent problem
19 then surely to goodness we would be seeing more
20 than Dr. Fowler's paper of what, 20 years ago
21 produced here? If that is the only paper we are
22 quoting?

23 Q. It may be ---

24 A. I mean I can't ---

25 Q. There may be others, Doctor,



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but what I would like to know from you, are you aware of any others, other than the one drawn to your attention of Dr. Fowler's which dealt as I have told you with the exception of two patients who did not have heart disease? Are you aware of any others that look specifically at that issue?

A. At the incidence of digitalis induced convulsions or seizures in children with serious heart disease?

Q. That is correct. That is my question.

A. I don't know any paper. Does anybody else?

Q. Not that we have heard of, Doctor.

A. No, thank you.

Q. Doctor, you were asked yesterday as well by Mr. Strathy whether you would agree that the doctors at the Hospital for Sick Children who actually observed a patient like these patients, these 36 ---

A. Yes.

Q. - in the Hospital setting, in a clinical context, would have what Mr. Strathy suggested was a distinct advantage over you in



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looking at the case from a second hand point of view from the chart and in trying to determine the reasons for a particular child's death.

Do you recall that question?

A. Yes, I do.

Q. And you said, as I understood your evidence, that yes, they would, that a doctor in that position, that is a doctor, an attending doctor, involved doctor from the Hospital for Sick Children, would have a better opportunity and would be in a position to observe, and your words were "A child's clinical course".

A. Yes.

Q. Do you recall that?

A. Yes.

Q. Doctor, do I take it correctly from that exchange with Mr. Strathy that the point which you were making was that the attending cardiologist was in a much better position than any physician who subsequently comes to review the chart insofar as the attending physician is assessing the clinical management and treatment of a patient?

A. Oh, I wouldn't have any doubt about that at all with regard to this group of physicians. No question about it, that they were



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looking after, caring for the child at the time,
and they were from day to day watching and discussing
and recording and doing what was necessary in the
management of the child, the diagnosis of the
child.

Yes, I agree with everything you
have said.

Q. Doctor, is it also your view
that that is necessarily the case as well, the
purpose of the review is to assess retrospectively
the cause of death?

A. No, you know, I don't think
it really is because I can put myself with patients
in my service in the same position, and I can agree
with you up to there.

Then if there is something develops
such as we all know about here, and some other
cardiologist is called in and told the sort of
thing that I was told, and told to look for the
possibility of digoxin intoxication in these
patients of mine in whom I have not suspected of
the death being due to digitalis overdoses in these
circumstances which he is being informed about now,
then he is bound to look at it from an entirely
different perspective.



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2 It doesn't mean to say that I don't
3 have a better appreciation of the child - a much
4 better appreciation of the child's on-going
5 condition, of the investigations that are being
6 done and so forth, and the day-to-day management.
7 That doesn't mean that at all, but it means now
8 that he is now looking at the charts after a problem
9 has been identified and clearly looks at that from
10 a different perspective. And that is what I have
11 been trying to make clear for the last three days
and I don't know whether I have succeeded.

12 But that is what I mean when I say
13 that I was called in to look at these deaths, the
14 charts of these children who had died. I was asked
15 to look for one specific reason: do you find
16 anything there which can in this setting (because
17 I knew the setting) make you suspicious that that
18 child might have died as a result of digitalis
overdosage.

19 Q. And for the purposes of that review,
20 Doctor, I take it you did not feel particularly
21 disadvantaged as compared to the position of any of
22 the attending physicians because you were looking
23 at it retrospectively from that point of view?
24 Is that right.
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A. I was looking at it from an entirely different point of view. I didn't discuss it with the attending physicians. I didn't go to any of the attending physicians, all of whom I know very well, to all of whom I refer patients, and some I have known for a quarter of a century - I didn't go to any of them and say now tell me what you thought about this and let's discuss it together.

10

11

Q. Doctor, does your hospital have a Mortality Review Committee?

12

A. They certainly do.

13

Q. How often does it meet?

14

A. Regularly.

15

Q. Do you participate in its meetings?

16

A. Yes.

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Q. Is its purpose to review all of the deaths in the Kingston General Hospital or only deaths on particular wards in the hospital?

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A. All the deaths are reviewed in the medical - in the Department of Medicine, whatever wards they occur on.

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The deaths are reviewed whether they have had autopsy or not. The deaths are reviewed to



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2 see whether there has been in the opinion of the
3 Reviewing Group anything that needs explaining,
4 anything which seems to be less than optimal in
5 the way of management and treatment or investigations,
6 and those that have been autopsied are presented
7 at 8 a.m. on the Wednesday morning with all house
8 staff, pathologists and clinicians present, and
9 are discussed in detail from the point of view
10 of what the clinical diagnosis was; what the
11 clinical course was, what the management was, what
12 investigation, instructions and so on, and then
13 the autopsy and the mode of death - the autopsy
14 findings are shown by the pathologist and there
15 is further discussion.

14 Q. Is one of the purposes of
15 the Committee's endeavours to determine the cause
16 of death of the child or at least discuss it?

17 A. Yes, yes, and to see if
18 management has been good as one might have hoped
19 it to be in our Centre.

20 Q. And I take it, Doctor, it
21 perhaps goes without saying that if mistakes have
22 been made the obvious hope is that the physicians
23 involved can learn from that for the betterment
24 of future patients? You are looking at it to see
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2 whether the treatment during life was optimal
3 and if not what can be done to improve in similar
4 situations in the future.

5 A. Well, I can tell you it gets
6 to be pretty critical at times.

7 Q. And, Doctor, in the course
8 of the kind of Mortality Review Committee that
9 your hospital has, would the physicians who sit
10 on that Committee necessarily have seen or treated
11 each of the children under review during life?

12 A. Oh, I am talking now about
13 adult patients, really because I have more adult
14 patients. No, they have not necessarily seen the
15 patient at all.

16 Q. Doctor, I have suggested for
17 the purpose of mortality assessment, if I might
18 ask you if you agree or disagree with it, for the
19 purposes of mortality assessments or determining
20 the cause of death in a number of children
21 retrospectively after they died, the reviewer,
22 the attending physician, I am sorry, who had been
23 involved in the treatment of the patient during
24 life may well be disadvantaged in the sense that
25 he or she deals with each child in isolation
whereas the Reviewing Committee looks at the number



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2 of deaths under review at once and from a far
3 different perspective.

4 Will you agree with me that there
5 may well be an advantage to that kind of a review
6 procedure that is not available to the individual
7 attending physician who is involved in each case
8 with the care of the child?

9 A. Well, of course there is some
10 truth in what you say. If you are charged with
11 the responsibility as we are on a rotational basis
12 to sit down and review all the deaths, you are
13 getting the broad perspective.

14 You know, I don't know from day to
15 day or week to day which deaths occurred on other
16 services particularly unless I had been involved
17 as a consultant, and what the autopsy showed,
18 and this sort of information isn't available to
19 me until I come to that Mortality Conference.
20 The group that is reviewing it is seeing for a
21 period of time the broad picture of deaths occurring
22 within our department.

23 Q. Doctor, your attention was
24 drawn this morning you may recall by Mr. Olah to
25 the cases of a number of children and he invited
you to put on what he described as a different pair



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of spectacles.

A. Yes.

Q. And you spoke with him about
Stephanie Lombardo - I'm sorry, Janice Estrella,
Jesse Belanger and a number of other cases.

I would like to draw or focus again
back to the 36 cases that you looked at together
as a group.

You told us you reviewed in fact
in excess I think you said 45 cases. These 36
were simply part of it. Is that right?

A. Well, I reviewed well over
40 cases.

Q. All right. And you were
reviewing them as a group, Doctor? You were
reviewing them as a group in the sense that you
looked at a large number of children?

A. Oh, yes.

Q. You looked at one chart
after another?

A. Yes, I did.

Q. And you knew as I understood
your exchange this afternoon with respect to these
36 that they all died within the same nine month
period of July, 1980 through to March 22nd, 1981?



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A. That I knew from the time I attended the first meeting at Police Headquarters that they had - that these deaths had occurred in the time frame.

Q. You knew as I understand it, Doctor, the mode of death in all of them because of course you went to the medical chart? You knew how they died?

A. Yes, I saw the report - I saw the autopsy report where it was available.

Q. All right. You knew, Doctor, that they had all died on the Cardiology Ward?

A. I knew they were all in the Cardiology Ward.

Q. Sitting here today, Doctor, many new factors or different factors have been drawn to your attention. In some cases the evidence of other witnesses before this Commission and in some cases a suggestion that certain of the digoxin levels may be invalid or at least questionable in regard to the nature of the specimen?

A. Yes.

Q. In the end, Doctor, having heard all those suggestions and bearing in mind the review that you did of these children, is your



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2 opinion, with respect, first, to Justin Cook whom
3 you placed you will recall in the probable category
4 any different today than it was when you completed
5 your review in the fall of 1982?

6 A . No, I have to leave it there
7 I think. I have to leave it at that.

8 Q. Thank you. You place, Doctor,
9 perhaps to do this by way of summary, you recall
10 8 children in your probable high suspicion category.
11 They were Justin Cook, Allana Miller, Kristin
12 Inwood, Kevin Pacsai, Janice Estrella, Jesse
Belanger, Stephanie Lombardo, Jordan Hines.

13 If you were asked today, Doctor,
14 fresh to start to rank these children knowing what
15 you do about the toxicology data that was available
16 and the features of their clinical course, the
17 nature of their deaths, in any of those cases I
18 invite you to tell me if your categorization would
be any different?

19 A. Well, I thought, of course --

20 MR. ROLAND: Is this assuming there
21 is more murders which is what the doctor assumed
22 at the beginning? Is this assuming there is a
murderer and a murder weapon?

23 MS. CRONK: My question to the doctor
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2 was quite specific.

3 MR. ROLAND: My friend has asked
4 him to do quite a different exercise than he has
5 done all the way through and he has told us
6 time and again what was his exercise. My friend
7 now says I want you to do a completely different
8 exercise.

9 If that is what she is saying,
10 it seems to be unfair to us and the doctor because
11 we could take him through a whole lot of other
12 assumptions then to look at afresh.

13 He assumed there were four murders,
14 there was a murderer and there was a murder weapon.
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MS. CRONK: I don't think that is entirely fair, sir. I thought I was careful in the way that I put the question and, that was, that several new factors had been put to the doctor in the course of the last three days, questions have been raised about the purity of certain samples, the efficacy of certain digoxin levels, the testimony of Doctors Rowe, Fowler, Freedom, Izukawa, MacLeod have been to him and my question really for your assistance, and I withdraw it if you think it improper in any way is simply at the end of the day before Dr. Fay leaves has he from his perspective, assessing the possible involvement of digoxin intoxication, altered his opinion, his categorization in any eight of those cases?

MR. ROLAND: Well, I want to put it clearly that I object to the question, whether you are going to allow it or not, and I object to it for this reason. I didn't take the doctor through each one of the babies that were in his category and read to him Dr. Rowe's evidence about it and Dr. Freedom's evidence and Dr. Rose's evidence about it and so on and asked him to decide in isolation, not assuming there is a murderer



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LL2 2 or a murder weapon, but decide in isolation what
3 his best judgment was about what the cause of
4 death was. I didn't do that and my friend didn't
5 ask him to do that exercise in chief either and
6 the reason I didn't is that's not what this doctor
7 had done. That wasn't the exercise that he was
8 retained to do and that's not what he did and
he kept telling us that.

9 THE COMMISSIONER: If it is any
10 comfort to you I am going to allow the question
11 but I am not going to pay a great deal of attention
12 to the answer because I am far more interested in
13 when each one was dealt with separately than I
14 am in the general because you get all the nuances
15 when you deal with each one separately. When you
16 ask one of these general questions such as this it
17 doesn't really assist us a great deal because
18 while he may say, all right, I will still leave it
19 in that possibility, he has been talking so much
20 about the variations in the various categories
that I am not too impressed with it.

21 MS. CRONK: I leave it entirely in
22 your hands, Mr. Commissioner, if it is of no
23 assistance to you, as I say, I withdraw it.

24 THE COMMISSIONER: I don't say it is
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2 of no assistance.

3 MR. ROLAND: Mr. Commissioner, the
4 underlying unfairness to the question is that the
5 doctor hasn't had put to him, and I can do it, I
6 can spend a couple of hours doing it but I didn't
7 put to him the opinion of the treating cardiologist,
8 Dr. Rowe, for instance, and the treating cardiologists
9 who gave us their best opinion, looking at each
10 case in isolation to say in this case or in that
11 case what they thought was the most likely cause
12 of death. Now, they had a lot of clinical infor-
13 mation that they provided to us. For this doctor
14 to do the same exercise they did looking at each
15 case in isolation, he should in fairness have that
16 clinical information before him before he can make
17 his opinion. He's told us that's how he approached
18 this exercise.

19 MS. CRONK: Well, I don't want to
20 make Mr. Roland's life any more difficult at this
21 hour, Mr. Commissioner. I thought it was clear
22 that not only does the witness not now looking at
23 these cases in isolation but that he never did, he
24 looked at them as a group.

25 THE COMMISSIONER: Yes, all right.

MS. CRONK: Doctor, I withdraw the



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2 question, thank you very much for your assistance
3 and your patience and we wish you well speed
4 back to Kingston. Thank you, sir.

5 THE WITNESS: Thank you.

6 THE COMMISSIONER: Thank you, Doctor.

7 THE WITNESS: Thank you, Mr.
8 Commissioner.

9 THE COMMISSIONER: Miss Cronk, do
10 you want to tell us something about next week?

11 MS. CRONK: Yes, sir. As counsel
12 are aware, Dr. Kauffman --

13 MR. YOUNG: Perhaps the witness could
14 be excused.

15 THE COMMISSIONER: Oh, yes, yes, the
16 witness is excused.

17 THE WITNESS: Thank you.

18 THE COMMISSIONER: The urgency excuse
19 is not present any more.

20 MR. YOUNG: There may be a later
21 train.

22 THE WITNESS: I don't think so.

23 THE COMMISSIONER: No, he has given
24 up on that and I don't want anybody following him
25 around to see what he does.

THE WITNESS: Thank you very much.



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2 THE COMMISSIONER: Not at all.

3 MS. CRONK: Mr. Commissioner, the
4 other counsel are aware, as are you, sir, that
5 Dr. Kauffman will be testifying commencing on
6 Monday morning. We have had provided to us later
7 this week certain of the materials that Dr. Kauffman
8 used in the course of his work for the Atlanta
9 Group, in preparation for the Atlanta report. We
10 are having it copied and I apologize they are not
11 ready this afternoon but I will see that they are
12 ready tomorrow and counsel who are interested in
13 having them over the weekend can arrange to have
14 them picked up or contact our office and we will
15 see what we can do.

16 THE COMMISSIONER: Yes. Dr. Kauffman
17 was the adviser, was he not, one of the advisers?

18 MS. CRONK: He was the clinical
19 pharmacologist who acted as a consultant to the
20 Atlanta Group and as well to the investigating
21 team.

22 THE COMMISSIONER: Well, there is
23 no problem so far as any of his evidence is
24 concerned, there is no problem with respect to the
25 deleted portion of the Atlanta report, is there?
He had nothing to do with that?

MS. CRONK: That's why, sir, they are



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2 not to be available today and are not going to be
3 available until tomorrow, we will have to go
4 through it.

5 THE COMMISSIONER: Oh, you are going
6 to see, you are going to try and make sure of that,
7 I see, all right.

8 MS. CRONK: That's right.

9 THE COMMISSIONER: Well, everybody
10 has to bear in mind the fact that Dr. Kauffman
11 was part of the Atlanta Group, it seems more
12 convenient to put him in now before the authors
13 of the Atlanta Report are there, that you have to
14 be careful in the examination not to deal with
15 those aspects.

16 MS. CRONK: Thank you, sir. They
17 will be ready tomorrow morning and, as I say, if
18 counsel wish to pick them up, they can contact our
19 office.

20 THE COMMISSIONER: Now, Miss Kitely,
21 what is your trouble?

22 MS. KITELY: You seem to speak down
23 on an important word. Are you saying, sir, that we
24 are not to cross-examine Dr. Kauffman ---

25 THE COMMISSIONER: No, no, you cross-
examine him on the Atlanta Report as much as you like



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2 but not on the aspects of - you don't know what
3 the parts are that have been excluded but I can
4 tell you they have something to do with some of
5 the people with whom you are concerned. So,
6 I don't want any questions being put to Dr. Kauffman
7 relating to that, do you understand?

8 MS. KITELY: Well, sir, I don't know
9 what it says, sir.

10 THE COMMISSIONER: All right. Well,
11 you spend the weekend guessing.

12 MS. KITELY: I spent months guessing.

13 THE COMMISSIONER: Okay. All right,
14 now, that's it?

15 MS. CRONK: Thank you, sir.

16 THE COMMISSIONER: Until 10 o'clock
17 on Monday morning.

18 --- Whereupon the hearing adjourned at 5:10 p.m.

19 until 10 a.m. Monday, the 28th day of November,
20 1983.

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